

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: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/29/2019 9:40 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/29/2019	Time: 9:40 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 HOLY FAMILY MEDICAL CENTER (14-2011) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ROBERT ROSENBERGER

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	424,583	50,850	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	424,583	50,850	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: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 9:40 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 100 NORTH RIVER ROAD, SECOND FLOOR			PO Box:				1.00	
2.00	City: DES PLAINES			State: IL		Zip Code: 60016		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			HOLY FAMILY MEDICAL CENTER	142011	16974	2	03/01/2006	N P P
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)						07/01/2018	06/30/2019	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 9:40 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 9:40 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

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 9:40 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 9:40 am
			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.	Y		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 1.00	XIX 2.00
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
			Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 9:40 am	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,261,992	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.06		122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H082		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 9:40 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: PRESENCE CARE TRASFORMATION CORP			Contractor's Name: NGS			Contractor's Number: 00131			
142.00	Street: 200 S. WACKER DRIVE			PO Box:						
143.00	City: CHICAGO			State: IL			Zip Code: 60606			
								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			
156.00	Subprovider - IPF			N	N	N	N			
157.00	Subprovider - IRF			N	N	N	N			
158.00	SUBPROVIDER									
159.00	SNF			N	N	N	N			
160.00	HOME HEALTH AGENCY			N	N	N	N			
161.00	CMHC				N	N	N			
								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.								N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									
						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: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/29/2019 9:40 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/21/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/29/2019 9:40 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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND		41.00
42.00	Enter the employer/company name of the cost report preparer	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8478133718	PATRICK.GILLILAND@AMITAHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/29/2019 9:40 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 9:40 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	120	43,800	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)		120	43,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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						13.00
14.00 Total (see instructions)		128	46,720	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)		128			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: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 9:40 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)	13,178	4,215	28,945			1.00
2.00	HMO and other (see instructions)	0	0				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)	13,178	4,215	28,945			7.00
8.00	INTENSIVE CARE UNIT	684	309	2,078			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)	13,862	4,524	31,023	0.00	427.56	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)			38			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	427.56	27.00
28.00	Observation Bed Days		0	0			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	0	0			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	1,425					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 9:40 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	461	140	1,409	1.00
2.00 HMO and other (see instructions)			0	0		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	461	140	1,409	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			79			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2011

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

Worksheet A

Date/Time Prepared:
11/29/2019 9:40 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		1,942,306	1,942,306	-368,912	1,573,394	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,771,649	4,771,649	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-116,781	356,117	239,336	-12	239,324	4.00
5.01	00540	NONPATIENT TELEPHONES	0	164,288	164,288	0	164,288	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	4,723,866	18,143,153	22,867,019	-1,758,252	21,108,767	5.06
6.00	00600	MAINTENANCE & REPAIRS	221,824	1,555,866	1,777,690	-3,434	1,774,256	6.00
7.00	00700	OPERATION OF PLANT	229,581	2,399,981	2,629,562	-41,759	2,587,803	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,823	242,807	317,630	-95,969	221,661	8.00
9.00	00900	HOUSEKEEPING	474,567	1,042,923	1,517,490	-13,531	1,503,959	9.00
10.00	01000	DIETARY	503,110	1,173,303	1,676,413	-551,456	1,124,957	10.00
11.00	01100	CAFETERIA	0	0	0	547,818	547,818	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	629,793	674,499	1,304,292	-193,446	1,110,846	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,348	312,323	408,671	-453,995	-45,324	14.00
15.00	01500	PHARMACY	870,285	3,266,582	4,136,867	-3,118,603	1,018,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	300	300	0	300	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	409,452	409,452	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,173,454	4,366,424	15,539,878	-1,665,547	13,874,331	30.00
31.00	03100	INTENSIVE CARE UNIT	1,690,220	613,743	2,303,963	-183,804	2,120,159	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	916,321	1,154,919	2,071,240	-507,431	1,563,809	50.00
53.00	05300	ANESTHESIOLOGY	0	638,115	638,115	-8,989	629,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,878	392,455	894,333	-263,210	631,123	54.00
56.00	05600	RADIOISOTOPE	40,420	24,058	64,478	-11,558	52,920	56.00
57.00	05700	CT SCAN	101,428	46,073	147,501	-11,377	136,124	57.00
57.01	03630	ULTRA SOUND	127,921	50,891	178,812	-25,865	152,947	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,492,496	2,492,496	-189,236	2,303,260	60.00
65.00	06500	RESPIRATORY THERAPY	2,731,844	1,009,823	3,741,667	-356,547	3,385,120	65.00
66.00	06600	PHYSICAL THERAPY	2,021,889	493,719	2,515,608	-29,073	2,486,535	66.00
69.00	06900	ELECTROCARDIOLOGY	42,209	15,954	58,163	-5,987	52,176	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,297	58,437	210,734	-7,319	203,415	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,405,213	2,405,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	596,841	596,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,343,880	3,343,880	73.00
74.00	07400	RENAL DIALYSIS	573,059	308,787	881,846	-108,616	773,230	74.00
76.00	03950	SUBSTANCE ABUSE	306,319	66,445	372,764	292,990	665,754	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	651,418	1,004,693	1,656,111	-793,832	862,279	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	6,125	6,125	-4,213	1,912	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	99,467	72,492	171,959	-22,476	149,483	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		1,573,394	1,573,394	-1,573,394	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,837,560	45,663,491	74,501,051	0	74,501,051	118.00
	NONREIMBURSABLE COST CENTERS							
200.00		TOTAL (SUM OF LINES 118 through 199)	28,837,560	45,663,491	74,501,051	0	74,501,051	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2011

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

Worksheet A

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,837,086	-263,692	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	399,243	5,170,892	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	301,742	541,066	4.00
5.01	00540	NONPATIENT TELEPHONES	0	164,288	5.01
5.02	00550	DATA PROCESSING	2,383,983	2,383,983	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	36,700	36,700	5.03
5.04	00570	ADMITTING	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	807,920	807,920	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-7,659,160	13,449,607	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	1,774,256	6.00
7.00	00700	OPERATION OF PLANT	34,151	2,621,954	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	967	222,628	8.00
9.00	00900	HOUSEKEEPING	0	1,503,959	9.00
10.00	01000	DIETARY	0	1,124,957	10.00
11.00	01100	CAFETERIA	-216,731	331,087	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,110,846	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-45,324	14.00
15.00	01500	PHARMACY	0	1,018,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338,103	338,403	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	409,452	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	13,874,331	30.00
31.00	03100	INTENSIVE CARE UNIT	174,150	2,294,309	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,563,809	50.00
53.00	05300	ANESTHESIOLOGY	-627,353	1,773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,790	625,333	54.00
56.00	05600	RADIOISOTOPE	0	52,920	56.00
57.00	05700	CT SCAN	0	136,124	57.00
57.01	03630	ULTRA SOUND	0	152,947	57.01
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	30,481	2,333,741	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,385,120	65.00
66.00	06600	PHYSICAL THERAPY	0	2,486,535	66.00
69.00	06900	ELECTROCARDIOLOGY	0	52,176	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	203,415	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,405,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	596,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,343,880	73.00
74.00	07400	RENAL DIALYSIS	0	773,230	74.00
76.00	03950	SUBSTANCE ABUSE	0	665,754	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	862,279	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,912	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	149,483	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,838,680	68,662,371	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,838,680	68,662,371	200.00

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 9:40 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,573,394		1.00
	TOTALS		0	1,573,394		
B - CAPITAL COSTS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,839,322		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
	TOTALS		0	3,839,322		
C - RECLASS DIETARY COSTS						
1.00	CAFETERIA	11.00	164,406	383,412		1.00
	TOTALS		164,406	383,412		
D - RECLASS SUPPLY COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,405,213		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	596,841		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
	TOTALS		0	3,002,054		
E - RECLASS DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,343,880		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	3,343,880		

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 9:40 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	F - RECLASS RESIDENCY COSTS				
1.00	I&R SERVICES-SALARY & FRINGES	21.00	380,873	28,579	1.00
	APPRV				
	TOTALS		380,873	28,579	
	G - RECLASS RENTAL COSTS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	932,327	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	932,327	
	H - RECLASS SUBSTANCE ABUSE				
1.00	SUBSTANCE ABUSE	76.00	232,120	60,870	1.00
	TOTALS		232,120	60,870	
500.00	Grand Total: Increases		777,399	13,163,838	500.00

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 9:40 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,573,394	11		1.00
	TOTALS		0	1,573,394			
	B - CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,942,306	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.06	0	1,298,465	9		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	1,104	0		3.00
4.00	OPERATION OF PLANT	7.00	0	39,145	0		4.00
5.00	HOUSEKEEPING	9.00	0	3,286	0		5.00
6.00	DIETARY	10.00	0	1,025	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	192,377	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,813	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	38,854	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,864	0		10.00
11.00	OPERATING ROOM	50.00	0	84,253	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	89,980	0		12.00
13.00	ULTRA SOUND	57.01	0	22,972	0		13.00
14.00	LABORATORY	60.00	0	38,135	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	8,857	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,072	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,000	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,100	0		18.00
19.00	WOMENS DIAGNOSTIC CENTER	90.02	0	20,714	0		19.00
	TOTALS		0	3,839,322			
	C - RECLASS DIETARY COSTS						
1.00	DIETARY	10.00	164,406	383,412	0		1.00
	TOTALS		164,406	383,412			
	D - RECLASS SUPPLY COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.06	0	15,439	0		2.00
3.00	OPERATION OF PLANT	7.00	0	905	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	95,858	0		4.00
5.00	HOUSEKEEPING	9.00	0	8,494	0		5.00
6.00	PHARMACY	15.00	0	2,747	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	1,187,446	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	166,229	0		8.00
9.00	OPERATING ROOM	50.00	0	396,725	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	7,851	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131,591	0		11.00
12.00	RADIOISOTOPE	56.00	0	8,907	0		12.00
13.00	CT SCAN	57.00	0	4,069	0		13.00
14.00	ULTRA SOUND	57.01	0	2,893	0		14.00
15.00	LABORATORY	60.00	0	142,920	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	315,952	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	14,496	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	2	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,284	0		19.00
20.00	RENAL DIALYSIS	74.00	0	98,703	0		20.00
21.00	HYPERBARIC OXYGEN THERAPY	76.98	0	398,531	0		21.00
	TOTALS		0	3,002,054			
	E - RECLASS DRUG COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.06	0	7,480	0		1.00
2.00	OPERATION OF PLANT	7.00	0	103	0		2.00
3.00	HOUSEKEEPING	9.00	0	19	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	309	0		4.00
5.00	PHARMACY	15.00	0	3,113,446	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	126,769	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	14,062	0		7.00
8.00	OPERATING ROOM	50.00	0	13,374	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	1,138	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,200	0		10.00
11.00	RADIOISOTOPE	56.00	0	226	0		11.00
12.00	CT SCAN	57.00	0	7,278	0		12.00
13.00	LABORATORY	60.00	0	279	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	3,029	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	206	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	11	0		16.00
17.00	RENAL DIALYSIS	74.00	0	9,894	0		17.00
18.00	HYPERBARIC OXYGEN THERAPY	76.98	0	8,645	0		18.00
19.00	CLINIC	90.00	0	404	0		19.00
20.00	WOMENS DIAGNOSTIC CENTER	90.02	0	8	0		20.00
	TOTALS		0	3,343,880			

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 9:40 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	F - RECLASS RESIDENCY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	380,873	28,579	0	1.00	
	TOTALS		380,873	28,579			
	G - RECLASS RENTAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,416	10	1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	2,330	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	1,606	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	111	0	4.00	
5.00	HOUSEKEEPING	9.00	0	1,732	0	5.00	
6.00	DIETARY	10.00	0	2,613	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	1,069	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	406,873	0	8.00	
9.00	PHARMACY	15.00	0	2,410	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	19,488	0	10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	649	0	11.00	
12.00	OPERATING ROOM	50.00	0	13,079	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,439	0	13.00	
14.00	RADIOISOTOPE	56.00	0	2,425	0	14.00	
15.00	CT SCAN	57.00	0	30	0	15.00	
16.00	LABORATORY	60.00	0	7,902	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	28,709	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	12,299	0	18.00	
19.00	ELECTROCARDIOLOGY	69.00	0	2,985	0	19.00	
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,924	0	20.00	
21.00	RENAL DIALYSIS	74.00	0	19	0	21.00	
22.00	HYPERBARIC OXYGEN THERAPY	76.98	0	386,656	0	22.00	
23.00	CLINIC	90.00	0	3,809	0	23.00	
24.00	WOMENS DIAGNOSTIC CENTER	90.02	0	1,754	0	24.00	
	TOTALS		0	932,327			
	H - RECLASS SUBSTANCE ABUSE						
1.00	ADULTS & PEDIATRICS	30.00	232,120	60,870	0	1.00	
	TOTALS		232,120	60,870			
500.00	Grand Total: Decreases		777,399	13,163,838		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/29/2019 9:40 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,320,000	0	0	0	0	1.00
2.00	Land Improvements	397,500	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,250,087	3,033,837	0	3,033,837	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,740,788	192,688	0	192,688	0	5.00
6.00	Movable Equipment	3,173,876	34,848	0	34,848	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,882,251	3,261,373	0	3,261,373	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,882,251	3,261,373	0	3,261,373	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,320,000	0				1.00
2.00	Land Improvements	397,500	0				2.00
3.00	Buildings and Fixtures	24,283,924	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,933,476	0				5.00
6.00	Movable Equipment	3,208,724	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	36,143,624	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	36,143,624	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,942,306	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,942,306	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	1,942,306				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,942,306				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	29,708,375	0	29,708,375	0.903478	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,173,876	0	3,173,876	0.096522	0	2.00
3.00	Total (sum of lines 1-2)	32,882,251	0	32,882,251	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,533,219	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	399,243	932,327	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,932,462	932,327	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	-2,796,911	0	0	0	-263,692	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,839,322	0	0	0	5,170,892	2.00
3.00	Total (sum of lines 1-2)	1,042,411	0	0	0	4,907,200	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2011

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-2,427,999	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)						
4.00	Investment income - other (chapter 2)						
5.00	Trade, quantity, and time discounts (chapter 8)						
6.00	Refunds and rebates of expenses (chapter 8)						
7.00	Rental of provider space by suppliers (chapter 8)						
8.00	Telephone services (pay stations excluded) (chapter 21)						
9.00	Television and radio service (chapter 21)						
10.00	Parking lot (chapter 21)						
11.00	Provider-based physician adjustment	A-8-2	-1,257,588				
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	-946,986				
14.00	Laundry and linen service						
15.00	Cafeteria-employees and guests	B	-216,731	CAFETERIA	11.00		
16.00	Rental of quarters to employee and others						
17.00	Sale of medical and surgical supplies to other than patients						
18.00	Sale of drugs to other than patients						
19.00	Sale of medical records and abstracts						
20.00	Nursing and allied health education (tuition, fees, books, etc.)						
21.00	Vending machines						
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-556,764	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	399,243	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
29.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
30.00	Physicians' assistant			*** Cost Center Deleted ***	0.00		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest						
33.00	OFFSET SUBSTANCE ABUSE REVENUE						
33.01	MISC ADMIN INCOME	B	-154,148	ADMINISTRATIVE & GENERAL	5.06		33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)						

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2011

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 9:40 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	
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00	OFFSET PATIENT TRANSPORT INCOME	B	-6,185	ADMINISTRATIVE & GENERAL	5.06	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	OFFSET CHILDCARE INCOME	B	-665,732	ADMINISTRATIVE & GENERAL	5.06	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
39.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.01
39.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.02
39.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.03
39.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.04
39.05	RADIOLOGY INCOME	B	-5,790	RADIOLOGY-DIAGNOSTIC	54.00	0	39.05
39.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,838,680				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: 14-2011

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2019 9:40 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	HOME OFFICE INTEREST	1,147,677	0 1.00
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	301,742	0 2.00
3.00		5.02	DATA PROCESSING	DATA PROCESSING	2,383,983	0 3.00
3.01		5.03	PURCHASING RECEIVING AND STO	MATERIALS MANAGEMENT	36,700	0 3.01
3.02		5.05	CASHIERING/ACCOUNTS RECEIVAB	BUSINESS OFFICE	807,920	0 3.02
3.03		5.06	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	2,561,310	8,799,260 3.03
3.04		7.00	OPERATION OF PLANT	FACILITY MANAGEMENT	34,151	0 3.04
3.05		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	967	0 3.05
3.06		16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	338,103	0 3.06
3.07		31.00	INTENSIVE CARE UNIT	TELE ICU	174,150	0 3.07
3.08		60.00	LABORATORY	ALVERNO LAB	2,327,970	2,262,399 3.08
4.00		0.00			0	0 4.00
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		10,114,673	11,061,659 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	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	PRESENCE CARE	100.00		0.00	6.00
7.00	C	ALVERNO LAB	66.67		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: 14-2011

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2019 9:40 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	1,147,677	9		1.00
2.00	301,742	9		2.00
3.00	2,383,983	0		3.00
3.01	36,700	0		3.01
3.02	807,920	0		3.02
3.03	-6,237,950	0		3.03
3.04	34,151	0		3.04
3.05	967	0		3.05
3.06	338,103	0		3.06
3.07	174,150	0		3.07
3.08	65,571	0		3.08
4.00	0	0		4.00
5.00	-946,986			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-2011

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2019 9:40 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	5.00	ADMINISTRATIVE & GENERAL	1,086,276	372,873	713,403	179,000	5,707	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	627,353	627,353	0	0	0	3.00
4.00	60.00	LABORATORY	35,090	35,090	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,748,719	1,035,316	713,403		5,707	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	491,131	24,557	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			491,131	24,557	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	491,131	222,272	595,145		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	627,353		3.00
4.00	60.00	LABORATORY	0	0	0	35,090		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	491,131	222,272	1,257,588		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	-263,692	-263,692			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,170,892		5,170,892		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	541,066	0	0	541,066	4.00
5.01	00540	NONPATIENT TELEPHONES	164,288	0	46,350	0	210,638
5.02	00550	DATA PROCESSING	2,383,983	0	0	0	14,323
5.03	00560	PURCHASING RECEIVING AND STORES	36,700	0	126,900	0	4,774
5.04	00570	ADMITTING	0	0	0	0	0
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	807,920	0	0	0	10,694
5.06	00590	ADMINISTRATIVE & GENERAL	13,449,607	0	798,372	81,158	37,239
6.00	00600	MAINTENANCE & REPAIRS	1,774,256	0	227,733	4,145	2,865
7.00	00700	OPERATION OF PLANT	2,621,954	0	865,468	4,290	4,010
8.00	00800	LAUNDRY & LINEN SERVICE	222,628	0	101,034	1,398	0
9.00	00900	HOUSEKEEPING	1,503,959	0	71,493	8,868	1,528
10.00	01000	DIETARY	1,124,957	0	293,563	6,329	1,337
11.00	01100	CAFETERIA	331,087	0	0	3,072	1,910
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,110,846	0	0	11,769	382
14.00	01400	CENTRAL SERVICES & SUPPLY	-45,324	0	142,303	1,800	1,910
15.00	01500	PHARMACY	1,018,264	0	82,117	16,263	4,201
16.00	01600	MEDICAL RECORDS & LIBRARY	338,403	0	78,441	0	13,941
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	409,452	0	0	7,117	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,874,331	0	686,172	204,459	52,515
31.00	03100	INTENSIVE CARE UNIT	2,294,309	0	78,241	31,585	955
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,563,809	0	570,337	17,123	16,805
53.00	05300	ANESTHESIOLOGY	1,773	0	2,249	0	1,337
54.00	05400	RADIOLOGY-DIAGNOSTIC	625,333	0	152,786	9,379	16,232
56.00	05600	RADIOISOTOPE	52,920	0	26,408	755	0
57.00	05700	CT SCAN	136,124	0	10,403	1,895	0
57.01	03630	ULTRA SOUND	152,947	0	14,359	2,390	0
58.00	05800	MRI	0	0	0	0	382
60.00	06000	LABORATORY	2,333,741	0	131,057	0	11,267
65.00	06500	RESPIRATORY THERAPY	3,385,120	0	10,684	51,050	4,583
66.00	06600	PHYSICAL THERAPY	2,486,535	0	240,124	37,783	4,201
69.00	06900	ELECTROCARDIOLOGY	52,176	0	28,798	789	0
70.00	07000	ELECTROENCEPHALOGRAPHY	203,415	0	61,452	2,846	2,292
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,405,213	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	596,841	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,343,880	0	0	0	0
74.00	07400	RENAL DIALYSIS	773,230	0	6,567	10,709	191
76.00	03950	SUBSTANCE ABUSE	665,754	0	180,118	10,062	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	862,279	0	9,579	12,173	382
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,912	0	70,549	0	0
90.02	09001	WOMENS DIAGNOSTIC CENTER	149,483	0	57,235	1,859	382
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,662,371	0	5,170,892	541,066	210,638
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		-263,692	0	0	0
202.00		TOTAL (sum lines 118 through 201)	68,662,371	-263,692	5,170,892	541,066	210,638

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,398,306					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	49,348	217,722				5.03
5.04	00570	ADMITTING	0	0	0			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	217,131	0	0	1,035,745		5.05
5.06	00590	ADMINISTRATIVE & GENERAL	730,343	2,807	0	0	15,099,526	5.06
6.00	00600	MAINTENANCE & REPAIRS	29,609	1,773	0	0	2,040,381	6.00
7.00	00700	OPERATION OF PLANT	9,870	1,002	0	0	3,506,594	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,870	4,702	0	0	339,632	8.00
9.00	00900	HOUSEKEEPING	9,870	3,154	0	0	1,598,872	9.00
10.00	01000	DIETARY	9,870	28,575	0	0	1,464,631	10.00
11.00	01100	CAFETERIA	9,870	0	0	0	345,939	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	529	0	0	1,123,526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,870	4,261	0	0	114,820	14.00
15.00	01500	PHARMACY	49,348	690	0	0	1,170,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217,131	0	0	0	647,916	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	416,569	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	138,174	58,157	0	342,761	15,356,569	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,528	0	33,907	2,448,525	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	128,304	32,029	0	32,760	2,361,167	50.00
53.00	05300	ANESTHESIOLOGY	0	472	0	6,350	12,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,696	7,419	0	13,815	1,150,660	54.00
56.00	05600	RADIOISOTOPE	0	464	0	1,246	81,793	56.00
57.00	05700	CT SCAN	0	236	0	11,758	160,416	57.00
57.01	03630	ULTRA SOUND	0	159	0	9,774	179,629	57.01
58.00	05800	MRI	9,870	0	0	0	10,252	58.00
60.00	06000	LABORATORY	256,609	7,263	0	89,833	2,829,770	60.00
65.00	06500	RESPIRATORY THERAPY	49,348	16,382	0	192,459	3,709,626	65.00
66.00	06600	PHYSICAL THERAPY	98,696	991	0	38,317	2,906,647	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6	0	7,347	89,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,609	235	0	7,005	306,854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	31,892	2,437,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,657	603,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	150,238	3,494,118	73.00
74.00	07400	RENAL DIALYSIS	0	4,940	0	27,560	823,197	74.00
76.00	03950	SUBSTANCE ABUSE	0	11,661	0	6,671	874,266	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	19,917	0	21,406	925,736	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	34	0	0	72,495	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	9,870	336	0	3,989	223,154	90.02
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)	2,398,306	217,722	0	1,035,745	68,926,063	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	-263,692	201.00
202.00		TOTAL (sum lines 118 through 201)	2,398,306	217,722	0	1,035,745	68,662,371	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL	15,099,526					5.06
6.00	00600	MAINTENANCE & REPAIRS	572,372	2,612,753				6.00
7.00	00700	OPERATION OF PLANT	983,677	569,366	5,059,637			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,274	66,467	164,580	665,953		8.00
9.00	00900	HOUSEKEEPING	448,519	47,033	116,459	0	2,210,883	9.00
10.00	01000	DIETARY	410,861	193,126	478,200	0	221,246	10.00
11.00	01100	CAFETERIA	97,044	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	315,174	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,210	93,617	231,805	0	107,248	14.00
15.00	01500	PHARMACY	328,458	54,022	133,764	0	61,888	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181,755	51,604	127,777	0	59,118	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	116,857	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,307,853	451,412	1,117,741	436,959	517,137	30.00
31.00	03100	INTENSIVE CARE UNIT	686,865	51,472	127,450	49,962	58,967	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	662,359	375,208	929,052	32,877	429,838	50.00
53.00	05300	ANESTHESIOLOGY	3,417	1,480	3,664	0	1,695	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,785	100,513	248,881	1,947	115,148	54.00
56.00	05600	RADIOISOTOPE	22,945	17,373	43,018	119	19,903	56.00
57.00	05700	CT SCAN	45,000	6,844	16,945	2,038	7,840	57.00
57.01	03630	ULTRA SOUND	50,390	9,446	23,390	3,209	10,822	57.01
58.00	05800	MRI	2,876	0	0	0	0	58.00
60.00	06000	LABORATORY	793,813	86,218	213,486	0	98,772	60.00
65.00	06500	RESPIRATORY THERAPY	1,040,632	7,029	17,403	303	8,052	65.00
66.00	06600	PHYSICAL THERAPY	815,378	157,970	391,151	21,165	180,971	66.00
69.00	06900	ELECTROCARDIOLOGY	24,999	18,945	46,911	527	21,704	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,079	40,427	100,102	749	46,314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	683,662	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,294	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	980,177	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	230,925	4,320	10,697	0	4,949	74.00
76.00	03950	SUBSTANCE ABUSE	245,251	118,494	293,404	87,612	135,747	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	259,689	6,302	15,604	25,838	7,219	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	20,336	46,412	114,921	103	53,170	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	62,600	37,653	93,232	2,545	43,135	90.02
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)	15,099,526	2,612,753	5,059,637	665,953	2,210,883	118.00
NONREIMBURSABLE COST CENTERS								
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)	15,099,526	2,612,753	5,059,637	665,953	2,210,883	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,768,064					10.00
11.00	01100	CAFETERIA	0	442,983				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	8,045	0	1,446,745		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,364	0	0	582,064	14.00
15.00	01500	PHARMACY	0	12,275	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,672,267	201,411	0	858,437	0	30.00
31.00	03100	INTENSIVE CARE UNIT	95,797	25,988	0	202,994	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,049	0	86,332	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,857	0	8,065	0	54.00
56.00	05600	RADIOISOTOPE	0	578	0	0	0	56.00
57.00	05700	CT SCAN	0	1,236	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	1,625	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	54,164	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	37,739	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	819	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,452	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	466,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	115,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	9,791	0	48,051	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	46,791	0	172,551	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	10,489	0	70,315	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	2,310	0	0	0	90.02
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)	2,768,064	442,983	0	1,446,745	582,064	118.00
NONREIMBURSABLE COST CENTERS								
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)	2,768,064	442,983	0	1,446,745	582,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,761,290					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,068,170				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	533,426		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	353,347	0	533,426	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	34,976	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,792	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	6,550	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,251	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	1,285	0	0	0	56.00
57.00	05700	CT SCAN	0	12,129	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	10,082	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	92,664	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	198,525	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39,525	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,578	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,226	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,897	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,866	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,761,290	154,974	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	28,428	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	6,881	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	22,080	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	4,114	0	0	0	90.02
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)	1,761,290	1,068,170	0	533,426	0	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,761,290	1,068,170	0	533,426	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	ADMINISTRATIVE & GENERAL				5.06
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,806,559	-533,426	26,273,133	30.00
31.00	03100	INTENSIVE CARE UNIT	3,782,996	0	3,782,996	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,926,674	0	4,926,674	50.00
53.00	05300	ANESTHESIOLOGY	28,987	0	28,987	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,970,107	0	1,970,107	54.00
56.00	05600	RADIOISOTOPE	187,014	0	187,014	56.00
57.00	05700	CT SCAN	252,448	0	252,448	57.00
57.01	03630	ULTRA SOUND	288,593	0	288,593	57.01
58.00	05800	MRI	13,128	0	13,128	58.00
60.00	06000	LABORATORY	4,114,723	0	4,114,723	60.00
65.00	06500	RESPIRATORY THERAPY	5,035,734	0	5,035,734	65.00
66.00	06600	PHYSICAL THERAPY	4,550,546	0	4,550,546	66.00
69.00	06900	ELECTROCARDIOLOGY	210,599	0	210,599	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	591,203	0	591,203	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,620,354	0	3,620,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,032	0	895,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,390,559	0	6,390,559	73.00
74.00	07400	RENAL DIALYSIS	1,160,358	0	1,160,358	74.00
76.00	03950	SUBSTANCE ABUSE	1,980,997	0	1,980,997	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,343,272	0	1,343,272	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	307,437	0	307,437	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	468,743	0	468,743	90.02
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)	68,926,063	-533,426	68,392,637	118.00
NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	-263,692	0	-263,692	201.00
202.00		TOTAL (sum lines 118 through 201)	68,662,371	-533,426	68,128,945	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	46,350	46,350	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	126,900	126,900	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	0	798,372	798,372	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	227,733	227,733	6.00
7.00	00700	OPERATION OF PLANT	0	0	865,468	865,468	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	101,034	101,034	8.00
9.00	00900	HOUSEKEEPING	0	0	71,493	71,493	9.00
10.00	01000	DIETARY	0	0	293,563	293,563	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	142,303	142,303	14.00
15.00	01500	PHARMACY	0	0	82,117	82,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	78,441	78,441	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	686,172	686,172	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	78,241	78,241	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	570,337	570,337	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,249	2,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	152,786	152,786	54.00
56.00	05600	RADIOISOTOPE	0	0	26,408	26,408	56.00
57.00	05700	CT SCAN	0	0	10,403	10,403	57.00
57.01	03630	ULTRA SOUND	0	0	14,359	14,359	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	131,057	131,057	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	10,684	10,684	65.00
66.00	06600	PHYSICAL THERAPY	0	0	240,124	240,124	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	28,798	28,798	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	61,452	61,452	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,567	6,567	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	180,118	180,118	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	9,579	9,579	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	70,549	70,549	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	57,235	57,235	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	5,170,892	5,170,892	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		-263,692	0	-263,692	201.00
202.00		TOTAL (sum lines 118 through 201)	0	-263,692	5,170,892	4,907,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	46,350					5.01
5.02	00550	DATA PROCESSING		3,152				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,051	65	128,016			5.03
5.04	00570	ADMITTING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,353	285	0	0	2,638	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	8,194	959	1,650	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	630	39	1,042	0	0	6.00
7.00	00700	OPERATION OF PLANT	882	13	589	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13	2,765	0	0	8.00
9.00	00900	HOUSEKEEPING	336	13	1,854	0	0	9.00
10.00	01000	DIETARY	294	13	16,801	0	0	10.00
11.00	01100	CAFETERIA	420	13	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	84	0	311	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	420	13	2,505	0	0	14.00
15.00	01500	PHARMACY	924	65	406	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,068	285	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,558	182	34,200	0	880	30.00
31.00	03100	INTENSIVE CARE UNIT	210	0	5,602	0	86	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,698	169	18,832	0	83	50.00
53.00	05300	ANESTHESIOLOGY	294	0	278	0	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,572	428	4,362	0	35	54.00
56.00	05600	RADIOISOTOPE	0	0	273	0	3	56.00
57.00	05700	CT SCAN	0	0	139	0	30	57.00
57.01	03630	ULTRA SOUND	0	0	93	0	25	57.01
58.00	05800	MRI	84	13	0	0	0	58.00
60.00	06000	LABORATORY	2,479	337	4,270	0	228	60.00
65.00	06500	RESPIRATORY THERAPY	1,009	65	9,632	0	488	65.00
66.00	06600	PHYSICAL THERAPY	924	130	583	0	97	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	504	39	138	0	18	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	81	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	381	73.00
74.00	07400	RENAL DIALYSIS	42	0	2,904	0	70	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	6,856	0	17	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	84	0	11,711	0	54	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	20	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	84	13	197	0	10	90.02
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)	46,350	3,152	128,016	0	2,638	118.00
NONREIMBURSABLE COST CENTERS								
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)	46,350	3,152	128,016	0	2,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL	809,175					5.06
6.00	00600	MAINTENANCE & REPAIRS	30,673	260,117				6.00
7.00	00700	OPERATION OF PLANT	52,715	56,685	976,352			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,106	6,617	31,759	147,294		8.00
9.00	00900	HOUSEKEEPING	24,036	4,682	22,473	0	124,887	9.00
10.00	01000	DIETARY	22,018	19,227	92,278	0	12,498	10.00
11.00	01100	CAFETERIA	5,201	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	16,890	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,726	9,320	44,731	0	6,058	14.00
15.00	01500	PHARMACY	17,602	5,378	25,812	0	3,496	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,740	5,138	24,657	0	3,339	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	6,262	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	230,853	44,941	215,689	96,643	29,212	30.00
31.00	03100	INTENSIVE CARE UNIT	36,809	5,124	24,594	11,051	3,331	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,495	37,354	179,278	7,272	24,280	50.00
53.00	05300	ANESTHESIOLOGY	183	147	707	0	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,298	10,007	48,026	431	6,504	54.00
56.00	05600	RADIOISOTOPE	1,230	1,730	8,301	26	1,124	56.00
57.00	05700	CT SCAN	2,412	681	3,270	451	443	57.00
57.01	03630	ULTRA SOUND	2,700	940	4,514	710	611	57.01
58.00	05800	MRI	154	0	0	0	0	58.00
60.00	06000	LABORATORY	42,540	8,584	41,196	0	5,579	60.00
65.00	06500	RESPIRATORY THERAPY	55,767	700	3,358	67	455	65.00
66.00	06600	PHYSICAL THERAPY	43,696	15,727	75,480	4,681	10,223	66.00
69.00	06900	ELECTROCARDIOLOGY	1,340	1,886	9,052	117	1,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,613	4,025	19,317	166	2,616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,637	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,072	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,527	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	12,375	430	2,064	0	280	74.00
76.00	03950	SUBSTANCE ABUSE	13,143	11,797	56,618	19,378	7,668	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	13,917	627	3,011	5,715	408	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,090	4,621	22,176	23	3,003	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	3,355	3,749	17,991	563	2,437	90.02
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)	809,175	260,117	976,352	147,294	124,887	118.00
NONREIMBURSABLE COST CENTERS								
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)	809,175	260,117	976,352	147,294	124,887	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	456,692					10.00
11.00	01100	CAFETERIA	0	5,634				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	102	0	17,387		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30	0	0	192,144	14.00
15.00	01500	PHARMACY	0	156	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	440,887	2,562	0	10,316	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,805	331	0	2,440	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	204	0	1,038	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100	0	97	0	54.00
56.00	05600	RADIOISOTOPE	0	7	0	0	0	56.00
57.00	05700	CT SCAN	0	16	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	21	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	689	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	480	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	154,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	38,086	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	125	0	577	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	595	0	2,074	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	133	0	845	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	29	0	0	0	90.02
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)	456,692	5,634	0	17,387	192,144	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	14,962	201.00
202.00		TOTAL (sum lines 118 through 201)	456,692	5,634	0	17,387	207,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	135,956					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124,668				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	6,262		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	41,308	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,079	0			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,941	0			50.00
53.00	05300	ANESTHESIOLOGY	0	764	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,662	0			54.00
56.00	05600	RADIOISOTOPE	0	150	0			56.00
57.00	05700	CT SCAN	0	1,414	0			57.00
57.01	03630	ULTRA SOUND	0	1,176	0			57.01
58.00	05800	MRI	0	0	0			58.00
60.00	06000	LABORATORY	0	10,806	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	23,151	0			65.00
66.00	06600	PHYSICAL THERAPY	0	4,609	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	884	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	843	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,836	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	801	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,956	18,072	0			73.00
74.00	07400	RENAL DIALYSIS	0	3,315	0			74.00
76.00	03950	SUBSTANCE ABUSE	0	802	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,575	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0			90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	480	0			90.02
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)	135,956	124,668	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments				6,262	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,956	124,668	0	6,262	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	ADMINISTRATIVE & GENERAL				5.06
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,845,403	0	1,845,403	30.00
31.00	03100	INTENSIVE CARE UNIT	187,703	0	187,703	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	881,981	0	881,981	50.00
53.00	05300	ANESTHESIOLOGY	4,734	0	4,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,308	0	245,308	54.00
56.00	05600	RADIOISOTOPE	39,252	0	39,252	56.00
57.00	05700	CT SCAN	19,259	0	19,259	57.00
57.01	03630	ULTRA SOUND	25,149	0	25,149	57.01
58.00	05800	MRI	251	0	251	58.00
60.00	06000	LABORATORY	247,076	0	247,076	60.00
65.00	06500	RESPIRATORY THERAPY	106,065	0	106,065	65.00
66.00	06600	PHYSICAL THERAPY	396,754	0	396,754	66.00
69.00	06900	ELECTROCARDIOLOGY	43,335	0	43,335	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,775	0	93,775	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,612	0	194,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,976	0	47,976	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,936	0	206,936	73.00
74.00	07400	RENAL DIALYSIS	28,749	0	28,749	74.00
76.00	03950	SUBSTANCE ABUSE	299,066	0	299,066	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	48,659	0	48,659	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,482	0	101,482	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	86,143	0	86,143	90.02
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)	5,149,668	0	5,149,668	118.00
NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments	6,262	0	6,262	200.00
201.00		Negative Cost Centers	-248,730	0	-248,730	201.00
202.00		TOTAL (sum lines 118 through 201)	4,907,200	0	4,907,200	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF LINES)	DATA PROCESSING (NUMBER OF INSTRUMENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	257,485					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		257,485				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	28,954,341			4.00
5.01	00540	NONPATIENT TELEPHONES	2,308	2,308	0	1,103		5.01
5.02	00550	DATA PROCESSING	0	0	0	75	243	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,319	6,319	0	25	5	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	56	22	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	39,755	39,755	4,342,993	195	74	5.06
6.00	00600	MAINTENANCE & REPAIRS	11,340	11,340	221,824	15	3	6.00
7.00	00700	OPERATION OF PLANT	43,096	43,096	229,581	21	1	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,031	5,031	74,823	0	1	8.00
9.00	00900	HOUSEKEEPING	3,560	3,560	474,567	8	1	9.00
10.00	01000	DIETARY	14,618	14,618	338,704	7	1	10.00
11.00	01100	CAFETERIA	0	0	164,406	10	1	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	629,793	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,086	7,086	96,348	10	1	14.00
15.00	01500	PHARMACY	4,089	4,089	870,285	22	5	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,906	3,906	0	73	22	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	380,873	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,168	34,168	10,941,334	275	14	30.00
31.00	03100	INTENSIVE CARE UNIT	3,896	3,896	1,690,220	5	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,400	28,400	916,321	88	13	50.00
53.00	05300	ANESTHESIOLOGY	112	112	0	7	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,608	7,608	501,878	85	33	54.00
56.00	05600	RADIOISOTOPE	1,315	1,315	40,420	0	0	56.00
57.00	05700	CT SCAN	518	518	101,428	0	0	57.00
57.01	03630	ULTRA SOUND	715	715	127,921	0	0	57.01
58.00	05800	MRI	0	0	0	2	1	58.00
60.00	06000	LABORATORY	6,526	6,526	0	59	26	60.00
65.00	06500	RESPIRATORY THERAPY	532	532	2,731,844	24	5	65.00
66.00	06600	PHYSICAL THERAPY	11,957	11,957	2,021,889	22	10	66.00
69.00	06900	ELECTROCARDIOLOGY	1,434	1,434	42,209	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,060	3,060	152,297	12	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	327	327	573,059	1	0	74.00
76.00	03950	SUBSTANCE ABUSE	8,969	8,969	538,439	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	477	477	651,418	2	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,513	3,513	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	2,850	2,850	99,467	2	1	90.02
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)	257,485	257,485	28,954,341	1,103	243	118.00
NONREIMBURSABLE COST CENTERS								
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)	-263,692	5,170,892	541,066	210,638	2,398,306	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	20.082304	0.018687	190.968268	9,869.572016	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	46,350	3,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	42.021759	12.971193	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF RE QUISITIONS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,438,315					5.03
5.04	00570	ADMITTING	0	0				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	375,253,174			5.05
5.06	00590	ADMINISTRATIVE & GENERAL	57,218	0	0	-15,099,526	53,826,537	5.06
6.00	00600	MAINTENANCE & REPAIRS	36,139	0	0	0	2,040,381	6.00
7.00	00700	OPERATION OF PLANT	20,433	0	0	0	3,506,594	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,858	0	0	0	339,632	8.00
9.00	00900	HOUSEKEEPING	64,290	0	0	0	1,598,872	9.00
10.00	01000	DIETARY	582,500	0	0	0	1,464,631	10.00
11.00	01100	CAFETERIA	0	0	0	0	345,939	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,786	0	0	0	1,123,526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,864	0	0	0	114,820	14.00
15.00	01500	PHARMACY	14,059	0	0	0	1,170,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	647,916	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	416,569	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,185,556	0	124,172,793	0	15,356,569	30.00
31.00	03100	INTENSIVE CARE UNIT	194,240	0	12,285,283	0	2,448,525	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	652,915	0	11,869,425	0	2,361,167	50.00
53.00	05300	ANESTHESIOLOGY	9,623	0	2,300,803	0	12,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,241	0	5,005,614	0	1,150,660	54.00
56.00	05600	RADIOISOTOPE	9,450	0	451,316	0	81,793	56.00
57.00	05700	CT SCAN	4,814	0	4,260,176	0	160,416	57.00
57.01	03630	ULTRA SOUND	3,239	0	3,541,320	0	179,629	57.01
58.00	05800	MRI	0	0	0	0	10,252	58.00
60.00	06000	LABORATORY	148,056	0	32,548,065	0	2,829,770	60.00
65.00	06500	RESPIRATORY THERAPY	333,949	0	69,731,374	0	3,709,626	65.00
66.00	06600	PHYSICAL THERAPY	20,209	0	13,883,095	0	2,906,647	66.00
69.00	06900	ELECTROCARDIOLOGY	117	0	2,661,822	0	89,116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,798	0	2,538,168	0	306,854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,554,899	0	2,437,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,411,776	0	603,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,433,994	0	3,494,118	73.00
74.00	07400	RENAL DIALYSIS	100,695	0	9,985,329	0	823,197	74.00
76.00	03950	SUBSTANCE ABUSE	237,709	0	2,417,069	0	874,266	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	406,014	0	7,755,657	0	925,736	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	703	0	0	0	72,495	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	6,840	0	1,445,196	0	223,154	90.02
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)	4,438,315	0	375,253,174	-15,099,526	53,826,537	118.00
NONREIMBURSABLE COST CENTERS								
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)	217,722	0	1,035,745		15,099,526	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.049055	0.000000	0.002760		0.280522	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,016	0	2,638		809,175	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028843	0.000000	0.000007		0.015033	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	197,763				6.00
7.00	00700	OPERATION OF PLANT	43,096	154,667			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,031	5,031	342,464		8.00
9.00	00900	HOUSEKEEPING	3,560	3,560	0	146,076	9.00
10.00	01000	DIETARY	14,618	14,618	0	14,618	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,086	7,086	0	7,086	14.00
15.00	01500	PHARMACY	4,089	4,089	0	4,089	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,906	3,906	0	3,906	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,168	34,168	224,705	34,168	30.00
31.00	03100	INTENSIVE CARE UNIT	3,896	3,896	25,693	3,896	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,400	28,400	16,907	28,400	50.00
53.00	05300	ANESTHESIOLOGY	112	112	0	112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,608	7,608	1,001	7,608	54.00
56.00	05600	RADIOISOTOPE	1,315	1,315	61	1,315	56.00
57.00	05700	CT SCAN	518	518	1,048	518	57.00
57.01	03630	ULTRA SOUND	715	715	1,650	715	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	6,526	6,526	0	6,526	60.00
65.00	06500	RESPIRATORY THERAPY	532	532	156	532	65.00
66.00	06600	PHYSICAL THERAPY	11,957	11,957	10,884	11,957	66.00
69.00	06900	ELECTROCARDIOLOGY	1,434	1,434	271	1,434	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,060	3,060	385	3,060	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	327	327	0	327	74.00
76.00	03950	SUBSTANCE ABUSE	8,969	8,969	45,054	8,969	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	477	477	13,287	477	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,513	3,513	53	3,513	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	2,850	2,850	1,309	2,850	90.02
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)	197,763	154,667	342,464	146,076	118.00
NONREIMBURSABLE COST CENTERS							
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)	2,612,753	5,059,637	665,953	2,210,883	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.211536	32.713100	1.944593	15.135156	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	260,117	976,352	147,294	124,887	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.315297	6.312607	0.430101	0.854945	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	32,984					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	599	0	12,736			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	176	0	0	3,016,754		14.00
15.00	01500	PHARMACY	914	0	0	0	3,343,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,997	0	7,557	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,935	0	1,787	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,195	0	760	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585	0	71	0	0	54.00
56.00	05600	RADIOISOTOPE	43	0	0	0	0	56.00
57.00	05700	CT SCAN	92	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	121	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,033	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,810	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	61	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	257	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,418,789	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	597,965	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,343,880	73.00
74.00	07400	RENAL DIALYSIS	729	0	423	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	3,484	0	1,519	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	781	0	619	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	172	0	0	0	0	90.02
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)	32,984	0	12,736	3,016,754	3,343,880	118.00
NONREIMBURSABLE COST CENTERS								
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)	442,983	0	1,446,745	582,064	1,761,290	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.430239	0.000000	113.594928	0.192944	0.526720	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,634	0	17,387	207,106	135,956	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.170810	0.000000	1.365185	0.063692	0.040658	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPROV (ASSIGNED TIME)		
				16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,253,174				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPROV			100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPROV	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	124,172,793	0	100	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,285,283	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,869,425	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,300,803	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,005,614	0	0	0	54.00
56.00	05600	RADIOISOTOPE	451,316	0	0	0	56.00
57.00	05700	CT SCAN	4,260,176	0	0	0	57.00
57.01	03630	ULTRA SOUND	3,541,320	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	32,548,065	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,731,374	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,883,095	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,661,822	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,538,168	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,554,899	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,411,776	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,433,994	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,985,329	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	2,417,069	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	7,755,657	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	1,445,196	0	0	0	90.02
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)	375,253,174	0	100	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,068,170	0	533,426	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002847	0.000000	5,334.260000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	124,668	0	6,262	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000332	0.000000	62.620000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 am

MCRIF32 - 15.9.167.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	124,172,793		124,172,793			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,285,283		12,285,283			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,988,810	8,880,615	11,869,425	0.415073	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	499,334	1,801,469	2,300,803	0.012599	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,687,061	1,318,553	5,005,614	0.393579	0.000000	54.00	
56.00	05600	RADIOISOTOPE	68,481	382,835	451,316	0.414375	0.000000	56.00	
57.00	05700	CT SCAN	3,054,970	1,205,206	4,260,176	0.059258	0.000000	57.00	
57.01	03630	ULTRA SOUND	838,542	2,702,778	3,541,320	0.081493	0.000000	57.01	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	24,235,163	8,312,902	32,548,065	0.126420	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	69,726,528	4,846	69,731,374	0.072216	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	10,978,019	2,905,076	13,883,095	0.327776	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,647,020	1,014,802	2,661,822	0.079118	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	85,505	2,452,663	2,538,168	0.232925	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,358,126	1,196,773	11,554,899	0.313318	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,378	1,812,398	2,411,776	0.371109	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	50,714,090	3,719,904	54,433,994	0.117400	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	8,524,803	1,460,526	9,985,329	0.116206	0.000000	74.00	
76.00	03950	SUBSTANCE ABUSE	1,259	2,415,810	2,417,069	0.819586	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	296,975	7,458,682	7,755,657	0.173199	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,445,196	1,445,196	0.324346	0.000000	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	324,762,140	50,491,034	375,253,174			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	324,762,140	50,491,034	375,253,174			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.415073		50.00
53.00	05300	ANESTHESIOLOGY	0.012599		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393579		54.00
56.00	05600	RADIOISOTOPE	0.414375		56.00
57.00	05700	CT SCAN	0.059258		57.00
57.01	03630	ULTRA SOUND	0.081493		57.01
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.126420		60.00
65.00	06500	RESPIRATORY THERAPY	0.072216		65.00
66.00	06600	PHYSICAL THERAPY	0.327776		66.00
69.00	06900	ELECTROCARDIOLOGY	0.079118		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232925		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.313318		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117400		73.00
74.00	07400	RENAL DIALYSIS	0.116206		74.00
76.00	03950	SUBSTANCE ABUSE	0.819586		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173199		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.324346		90.02
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 am

				Title XIX		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	26,273,133		26,273,133	0	26,273,133	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,782,996		3,782,996	0	3,782,996	31.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,926,674		4,926,674	0	4,926,674	50.00	
53.00	05300	ANESTHESIOLOGY	28,987		28,987	0	28,987	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,970,107		1,970,107	0	1,970,107	54.00	
56.00	05600	RADIOISOTOPE	187,014		187,014	0	187,014	56.00	
57.00	05700	CT SCAN	252,448		252,448	0	252,448	57.00	
57.01	03630	ULTRA SOUND	288,593		288,593	0	288,593	57.01	
58.00	05800	MRI	13,128		13,128	0	13,128	58.00	
60.00	06000	LABORATORY	4,114,723		4,114,723	0	4,114,723	60.00	
65.00	06500	RESPIRATORY THERAPY	5,035,734	0	5,035,734	0	5,035,734	65.00	
66.00	06600	PHYSICAL THERAPY	4,550,546	0	4,550,546	0	4,550,546	66.00	
69.00	06900	ELECTROCARDIOLOGY	210,599		210,599	0	210,599	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	591,203		591,203	0	591,203	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,620,354		3,620,354	0	3,620,354	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,032		895,032	0	895,032	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,390,559		6,390,559	0	6,390,559	73.00	
74.00	07400	RENAL DIALYSIS	1,160,358		1,160,358	0	1,160,358	74.00	
76.00	03950	SUBSTANCE ABUSE	1,980,997		1,980,997	0	1,980,997	76.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,343,272		1,343,272	0	1,343,272	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	307,437		307,437	0	307,437	90.00	
90.02	09001	WOMENS DIAGNOSTIC CENTER	468,743		468,743	0	468,743	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	68,392,637	0	68,392,637	0	68,392,637	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	68,392,637	0	68,392,637	0	68,392,637	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 am

			Title XIX			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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	124,172,793		124,172,793			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,285,283		12,285,283			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,988,810	8,880,615	11,869,425	0.415073	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	499,334	1,801,469	2,300,803	0.012599	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,687,061	1,318,553	5,005,614	0.393579	0.000000	54.00	
56.00	05600	RADIOISOTOPE	68,481	382,835	451,316	0.414375	0.000000	56.00	
57.00	05700	CT SCAN	3,054,970	1,205,206	4,260,176	0.059258	0.000000	57.00	
57.01	03630	ULTRA SOUND	838,542	2,702,778	3,541,320	0.081493	0.000000	57.01	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	24,235,163	8,312,902	32,548,065	0.126420	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	69,726,528	4,846	69,731,374	0.072216	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	10,978,019	2,905,076	13,883,095	0.327776	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,647,020	1,014,802	2,661,822	0.079118	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	85,505	2,452,663	2,538,168	0.232925	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,358,126	1,196,773	11,554,899	0.313318	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,378	1,812,398	2,411,776	0.371109	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	50,714,090	3,719,904	54,433,994	0.117400	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	8,524,803	1,460,526	9,985,329	0.116206	0.000000	74.00	
76.00	03950	SUBSTANCE ABUSE	1,259	2,415,810	2,417,069	0.819586	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	296,975	7,458,682	7,755,657	0.173199	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,445,196	1,445,196	0.324346	0.000000	90.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	324,762,140	50,491,034	375,253,174			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	324,762,140	50,491,034	375,253,174			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.415073			50.00
53.00	05300	ANESTHESIOLOGY	0.012599			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393579			54.00
56.00	05600	RADIOISOTOPE	0.414375			56.00
57.00	05700	CT SCAN	0.059258			57.00
57.01	03630	ULTRA SOUND	0.081493			57.01
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.126420			60.00
65.00	06500	RESPIRATORY THERAPY	0.072216			65.00
66.00	06600	PHYSICAL THERAPY	0.327776			66.00
69.00	06900	ELECTROCARDIOLOGY	0.079118			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232925			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.313318			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371109			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117400			73.00
74.00	07400	RENAL DIALYSIS	0.116206			74.00
76.00	03950	SUBSTANCE ABUSE	0.819586			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173199			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.324346			90.02
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,926,674	881,981	4,044,693	0	0
53.00	05300	ANESTHESIOLOGY	28,987	4,734	24,253	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,970,107	245,308	1,724,799	0	0
56.00	05600	RADIOISOTOPE	187,014	39,252	147,762	0	0
57.00	05700	CT SCAN	252,448	19,259	233,189	0	0
57.01	03630	ULTRA SOUND	288,593	25,149	263,444	0	0
58.00	05800	MRI	13,128	251	12,877	0	0
60.00	06000	LABORATORY	4,114,723	247,076	3,867,647	0	0
65.00	06500	RESPIRATORY THERAPY	5,035,734	106,065	4,929,669	0	0
66.00	06600	PHYSICAL THERAPY	4,550,546	396,754	4,153,792	0	0
69.00	06900	ELECTROCARDIOLOGY	210,599	43,335	167,264	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	591,203	93,775	497,428	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,620,354	194,612	3,425,742	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,032	47,976	847,056	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,390,559	206,936	6,183,623	0	0
74.00	07400	RENAL DIALYSIS	1,160,358	28,749	1,131,609	0	0
76.00	03950	SUBSTANCE ABUSE	1,980,997	299,066	1,681,931	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,343,272	48,659	1,294,613	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	307,437	101,482	205,955	0	0
90.02	09001	WOMENS DIAGNOSTIC CENTER	468,743	86,143	382,600	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	38,336,508	3,116,562	35,219,946	0	0
201.00		Less Observation Beds	0	0	0	0	0
202.00		Total (line 200 minus line 201)	38,336,508	3,116,562	35,219,946	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/29/2019 9:40 am

				Title XIX		Hospital		PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)				
			6.00	7.00	8.00				
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,926,674	11,869,425	0.415073				50.00
53.00	05300	ANESTHESIOLOGY	28,987	2,300,803	0.012599				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,970,107	5,005,614	0.393579				54.00
56.00	05600	RADIOISOTOPE	187,014	451,316	0.414375				56.00
57.00	05700	CT SCAN	252,448	4,260,176	0.059258				57.00
57.01	03630	ULTRA SOUND	288,593	3,541,320	0.081493				57.01
58.00	05800	MRI	13,128	0	0.000000				58.00
60.00	06000	LABORATORY	4,114,723	32,548,065	0.126420				60.00
65.00	06500	RESPIRATORY THERAPY	5,035,734	69,731,374	0.072216				65.00
66.00	06600	PHYSICAL THERAPY	4,550,546	13,883,095	0.327776				66.00
69.00	06900	ELECTROCARDIOLOGY	210,599	2,661,822	0.079118				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	591,203	2,538,168	0.232925				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,620,354	11,554,899	0.313318				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,032	2,411,776	0.371109				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,390,559	54,433,994	0.117400				73.00
74.00	07400	RENAL DIALYSIS	1,160,358	9,985,329	0.116206				74.00
76.00	03950	SUBSTANCE ABUSE	1,980,997	2,417,069	0.819586				76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,343,272	7,755,657	0.173199				76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000				76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	307,437	0	0.000000				90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	468,743	1,445,196	0.324346				90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000				92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (sum of lines 50 thru 199)	38,336,508	238,795,098					200.00
201.00		Less Observation Beds	0	0					201.00
202.00		Total (line 200 minus line 201)	38,336,508	238,795,098					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,845,403	0	1,845,403	28,945	63.76	30.00
31.00	INTENSIVE CARE UNIT		187,703		187,703	2,078	90.33	31.00
200.00	Total (lines 30 through 199)		2,033,106		2,033,106	31,023		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		13,178	840,229				
31.00	INTENSIVE CARE UNIT		684	61,786				
200.00	Total (lines 30 through 199)		13,862	902,015				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/29/2019 9:40 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	881,981	11,869,425	0.074307	1,205,254	89,559	50.00
53.00	05300	ANESTHESIOLOGY	4,734	2,300,803	0.002058	235,454	485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,308	5,005,614	0.049007	1,994,520	97,745	54.00
56.00	05600	RADIOISOTOPE	39,252	451,316	0.086972	33,460	2,910	56.00
57.00	05700	CT SCAN	19,259	4,260,176	0.004521	1,540,581	6,965	57.00
57.01	03630	ULTRA SOUND	25,149	3,541,320	0.007102	451,020	3,203	57.01
58.00	05800	MRI	251	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	247,076	32,548,065	0.007591	11,671,827	88,601	60.00
65.00	06500	RESPIRATORY THERAPY	106,065	69,731,374	0.001521	35,405,076	53,851	65.00
66.00	06600	PHYSICAL THERAPY	396,754	13,883,095	0.028578	5,492,688	156,970	66.00
69.00	06900	ELECTROCARDIOLOGY	43,335	2,661,822	0.016280	872,707	14,208	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,775	2,538,168	0.036946	41,752	1,543	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,612	11,554,899	0.016842	5,448,390	91,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,976	2,411,776	0.019892	308,131	6,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,936	54,433,994	0.003802	24,155,478	91,839	73.00
74.00	07400	RENAL DIALYSIS	28,749	9,985,329	0.002879	5,284,879	15,215	74.00
76.00	03950	SUBSTANCE ABUSE	299,066	2,417,069	0.123731	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	48,659	7,755,657	0.006274	312	2	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	101,482	0	0.000000	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	86,143	1,445,196	0.059606	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,116,562	238,795,098		94,141,529	720,987	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/29/2019 9:40 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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	28,945	0.00	13,178			30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,078	0.00	684			31.00	
200.00		Total (lines 30 through 199)		0	31,023		13,862			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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 9:40 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 9:40 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	11,869,425	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,300,803	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,005,614	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	451,316	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,260,176	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	3,541,320	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	32,548,065	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	69,731,374	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,883,095	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,661,822	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,538,168	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,554,899	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,411,776	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,433,994	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	9,985,329	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	2,417,069	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	7,755,657	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	1,445,196	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	238,795,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 9:40 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	1,205,254	0	3,189,890	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	235,454	0	703,542	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,994,520	0	350,823	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	33,460	0	147,118	0	56.00
57.00	05700	CT SCAN	0.000000	1,540,581	0	597,708	0	57.00
57.01	03630	ULTRA SOUND	0.000000	451,020	0	474,402	0	57.01
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	11,671,827	0	1,179,586	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	35,405,076	0	929	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,492,688	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	872,707	0	343,087	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	41,752	0	489,035	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,448,390	0	529,282	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	308,131	0	866,063	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	24,155,478	0	3,360,266	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	5,284,879	0	1,460,526	0	74.00
76.00	03950	SUBSTANCE ABUSE	0.000000	0	0	49	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	312	0	2,108,531	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.000000	0	0	182,723	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		94,141,529	0	15,983,560	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/29/2019 9:40 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	0.415073	3,189,890	0	0	1,324,037	50.00
53.00	05300	ANESTHESIOLOGY	0.012599	703,542	0	0	8,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393579	350,823	0	0	138,077	54.00
56.00	05600	RADIOISOTOPE	0.414375	147,118	0	0	60,962	56.00
57.00	05700	CT SCAN	0.059258	597,708	0	0	35,419	57.00
57.01	03630	ULTRA SOUND	0.081493	474,402	0	0	38,660	57.01
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.126420	1,179,586	0	0	149,123	60.00
65.00	06500	RESPIRATORY THERAPY	0.072216	929	0	0	67	65.00
66.00	06600	PHYSICAL THERAPY	0.327776	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079118	343,087	0	0	27,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232925	489,035	0	0	113,908	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.313318	529,282	0	0	165,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371109	866,063	20,500	0	321,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117400	3,360,266	0	44,109	394,495	73.00
74.00	07400	RENAL DIALYSIS	0.116206	1,460,526	0	0	169,722	74.00
76.00	03950	SUBSTANCE ABUSE	0.819586	49	0	0	40	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173199	2,108,531	0	0	365,195	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.324346	182,723	0	0	59,265	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		15,983,560	20,500	44,109	3,372,216	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		15,983,560	20,500	44,109	3,372,216	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/29/2019 9:40 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
57.01	03630	ULTRA SOUND	0	0					57.01
58.00	05800	MRI	0	0					58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,608	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,178					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	SUBSTANCE ABUSE	0	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0					90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	7,608	5,178					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	7,608	5,178					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,845,403	0	1,845,403	28,945	63.76	30.00
31.00	INTENSIVE CARE UNIT		187,703		187,703	2,078	90.33	31.00
200.00	Total (lines 30 through 199)		2,033,106		2,033,106	31,023		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		4,215	268,748				
31.00	INTENSIVE CARE UNIT		309	27,912				
200.00	Total (lines 30 through 199)		4,524	296,660				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Title XIX		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	881,981	11,869,425	0.074307	45,784	3,402 50.00
53.00	05300	ANESTHESIOLOGY	4,734	2,300,803	0.002058	11,183	23 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,308	5,005,614	0.049007	134,446	6,589 54.00
56.00	05600	RADIOISOTOPE	39,252	451,316	0.086972	5,446	474 56.00
57.00	05700	CT SCAN	19,259	4,260,176	0.004521	205,225	928 57.00
57.01	03630	ULTRA SOUND	25,149	3,541,320	0.007102	70,196	499 57.01
58.00	05800	MRI	251	0	0.000000	0	0 58.00
60.00	06000	LABORATORY	247,076	32,548,065	0.007591	1,233,992	9,367 60.00
65.00	06500	RESPIRATORY THERAPY	106,065	69,731,374	0.001521	1,977,157	3,007 65.00
66.00	06600	PHYSICAL THERAPY	396,754	13,883,095	0.028578	666,476	19,047 66.00
69.00	06900	ELECTROCARDIOLOGY	43,335	2,661,822	0.016280	87,107	1,418 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,775	2,538,168	0.036946	5,777	213 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,612	11,554,899	0.016842	1,052,041	17,718 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,976	2,411,776	0.019892	6,902	137 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,936	54,433,994	0.003802	4,311,442	16,392 73.00
74.00	07400	RENAL DIALYSIS	28,749	9,985,329	0.002879	70,782	204 74.00
76.00	03950	SUBSTANCE ABUSE	299,066	2,417,069	0.123731	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	48,659	7,755,657	0.006274	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	101,482	0	0.000000	0	0 90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	86,143	1,445,196	0.059606	0	0 90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	3,116,562	238,795,098		9,883,956	79,418 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/29/2019 9:40 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	28,945	0.00	4,215	0.00	309	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,078	0.00	309			31.00	
200.00		Total (lines 30 through 199)		0	31,023		4,524			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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 9:40 am	
			Title XIX		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 9:40 am

			Title XIX			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	11,869,425	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,300,803	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,005,614	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	451,316	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	4,260,176	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	3,541,320	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	32,548,065	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	69,731,374	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,883,095	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,661,822	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,538,168	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,554,899	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,411,776	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,433,994	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	9,985,329	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	2,417,069	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	7,755,657	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	1,445,196	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	238,795,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-2011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 9:40 am	
Cost Center Description				Title XIX		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	45,784	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	11,183	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	134,446	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	5,446	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	205,225	0	0	0	57.00
57.01	03630	ULTRA SOUND		0.000000	70,196	0	0	0	57.01
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	1,233,992	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,977,157	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	666,476	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	87,107	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	5,777	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	1,052,041	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	6,902	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	4,311,442	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	70,782	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER		0.000000	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			9,883,956	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 9:40 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)	28,945	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,945	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)	28,945	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)	13,178	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)	26,273,133	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)	26,273,133	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)	26,273,133	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)	907.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,961,539	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)	11,961,539	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:

11/29/2019 9:40 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,782,996	2,078	1,820.50	684	1,245,222	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)					12,613,126	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,819,887	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)					902,015	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					720,987	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,623,002	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,196,885	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,845,403	26,273,133	0.070239	0	0 90.00
91.00	Nursing School cost	0	26,273,133	0.000000	0	0 91.00
92.00	Allied health cost	0	26,273,133	0.000000	0	0 92.00
93.00	All other Medical Education	0	26,273,133	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,945	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,945	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)		28,945	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)		4,215	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)		26,273,133	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)		26,273,133	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)		26,273,133	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)		907.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,825,913	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,825,913	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Title XIX		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)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	3,782,996	2,078	1,820.50	309	562,535
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)					1,464,246
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,852,694
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					296,660
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					79,418
52.00	Total Program excludable cost (sum of lines 50 and 51)					376,078
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,476,616
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-2011

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,845,403	26,273,133	0.070239	0	0 90.00
91.00	Nursing School cost	0	26,273,133	0.000000	0	0 91.00
92.00	Allied health cost	0	26,273,133	0.000000	0	0 92.00
93.00	All other Medical Education	0	26,273,133	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/29/2019 9:40 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		56,917,154		30.00
31.00	03100	INTENSIVE CARE UNIT		6,588,162		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.415073	1,205,254	500,268	50.00
53.00	05300	ANESTHESIOLOGY	0.012599	235,454	2,966	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393579	1,994,520	785,001	54.00
56.00	05600	RADIOISOTOPE	0.414375	33,460	13,865	56.00
57.00	05700	CT SCAN	0.059258	1,540,581	91,292	57.00
57.01	03630	ULTRA SOUND	0.081493	451,020	36,755	57.01
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.126420	11,671,827	1,475,552	60.00
65.00	06500	RESPIRATORY THERAPY	0.072216	35,405,076	2,556,813	65.00
66.00	06600	PHYSICAL THERAPY	0.327776	5,492,688	1,800,371	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079118	872,707	69,047	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232925	41,752	9,725	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.313318	5,448,390	1,707,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371109	308,131	114,350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117400	24,155,478	2,835,853	73.00
74.00	07400	RENAL DIALYSIS	0.116206	5,284,879	614,135	74.00
76.00	03950	SUBSTANCE ABUSE	0.819586	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173199	312	54	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.324346	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		94,141,529	12,613,126	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)		94,141,529	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/29/2019 9:40 am	
			Title XIX	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		7,441,237		30.00
31.00	03100	INTENSIVE CARE UNIT		230,470		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.415073	45,784	19,004	50.00
53.00	05300	ANESTHESIOLOGY	0.012599	11,183	141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393579	134,446	52,915	54.00
56.00	05600	RADIOISOTOPE	0.414375	5,446	2,257	56.00
57.00	05700	CT SCAN	0.059258	205,225	12,161	57.00
57.01	03630	ULTRA SOUND	0.081493	70,196	5,720	57.01
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.126420	1,233,992	156,001	60.00
65.00	06500	RESPIRATORY THERAPY	0.072216	1,977,157	142,782	65.00
66.00	06600	PHYSICAL THERAPY	0.327776	666,476	218,455	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079118	87,107	6,892	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232925	5,777	1,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.313318	1,052,041	329,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371109	6,902	2,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117400	4,311,442	506,163	73.00
74.00	07400	RENAL DIALYSIS	0.116206	70,782	8,225	74.00
76.00	03950	SUBSTANCE ABUSE	0.819586	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.173199	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.324346	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,883,956	1,464,246	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)		9,883,956	0	202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2019 9:40 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	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
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	7.00
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	0.0000	0.0000	0.0000	0.0000	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
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	0	0	0	0	0
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	0	0	0	0	0
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
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	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2019 9:40 am

		Title XVIII		Hospital		PPS	
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0
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	0	0	0	0	0
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	0
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	0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0
		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	0
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				100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 9:40 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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	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	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	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	0	0	0	0	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	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 9:40 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	0	0	0	0	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	0	0	0	0	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	0	0	0	0	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	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/29/2019 9:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,786	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,372,216	2.00
3.00	OPPS payments		2,052,571	3.00
4.00	Outlier payment (see instructions)		59,098	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)		12,786	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		64,609	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)		64,609	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		64,609	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		51,823	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)		12,786	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,111,669	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		4,100	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		420,081	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,700,274	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		275	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,700,549	30.00
31.00	Primary payer payments		424	31.00
32.00	Subtotal (line 30 minus line 31)		1,700,125	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)		65,377	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		42,495	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,725	36.00
37.00	Subtotal (see instructions)		1,742,620	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,742,620	40.00
40.01	Sequestration adjustment (see instructions)		34,852	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,656,918	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		50,850	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: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/29/2019 9:40 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		23,009,598		1,656,918	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)		23,009,598		1,656,918	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		424,583		50,850	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		23,434,181		1,707,768	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: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/29/2019 9:40 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part IV Date/Time Prepared: 11/29/2019 9:40 am
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		23,425,682	1.00
1.01	Full standard payment amount		19,644,056	1.01
1.02	Short stay outlier standard payment amount		3,423,876	1.02
1.03	Site neutral payment amount - Cost		28,560	1.03
1.04	Site neutral payment amount - IPPS comparable		329,190	1.04
2.00	Outlier Payments		2,480,776	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		25,906,458	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		25,906,458	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		25,906,458	9.00
10.00	Deductibles		53,888	10.00
11.00	Subtotal (line 9 minus line 10)		25,852,570	11.00
12.00	Coinsurance		2,373,388	12.00
13.00	Subtotal (line 11 minus line 12)		23,479,182	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		663,313	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		431,153	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		595,510	16.00
17.00	Subtotal (sum of lines 13 and 15)		23,910,335	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		2,095	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		23,912,430	22.00
22.01	Sequestration adjustment (see instructions)		478,249	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		23,009,598	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		424,583	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		2,480,776	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2019 9:40 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,441,237		8.00
9.00	Ancillary service charges		9,883,956	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,325,193	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,325,193	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,325,193	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments			0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0		26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/29/2019 9:40 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			2.73	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.19	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-1.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.54	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.06	0.04		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.02	0.02		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.03	0.02		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.03	0.02		17.00
18.00	Per resident amount	105,308.58	107,226.00		18.00
19.00	Approved amount for resident costs	3,159	2,145	5,304	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			5,304	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	13,862	0		26.00
27.00	Total Inpatient Days (see instructions)	31,023	31,023		27.00
28.00	Ratio of inpatient days to total inpatient days	0.446830	0.000000		28.00
29.00	Program direct GME amount	2,370	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			2,370	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-2011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/29/2019 9:40 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			9,985,329	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			25,819,887	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			25,819,887	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			3,385,002	42.00
43.00	Primary payer payments (see instructions)			424	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			3,384,578	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			29,204,465	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.884108	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.115892	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			2,370	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			2,095	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			275	50.00

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

Provider CCN: 14-2011

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

Worksheet G

Date/Time Prepared:
11/29/2019 9:40 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	5,573	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	62,036,294	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-45,765,817	0	0	0	6.00
7.00	Inventory	940,741	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	47,013	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)	17,263,804	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,320,000	0	0	0	12.00
13.00	Land improvements	397,500	0	0	0	13.00
14.00	Accumulated depreciation	-33,667	0	0	0	14.00
15.00	Buildings	24,283,924	0	0	0	15.00
16.00	Accumulated depreciation	-1,452,447	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	1,933,476	0	0	0	19.00
20.00	Accumulated depreciation	-549,460	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	3,208,725	0	0	0	23.00
24.00	Accumulated depreciation	-604,587	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,503,464	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,283,745	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,283,745	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,051,013	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	134,532	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	92,047	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	9,256,755	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,483,334	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,483,334	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	42,567,679	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	42,567,679	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,051,013	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2011

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

Worksheet G-1

Date/Time Prepared:
11/29/2019 9:40 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		44,887,453		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,319,774				2.00
3.00	Total (sum of line 1 and line 2)		42,567,679		0		3.00
4.00	RECONCILING ITEM	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		42,567,679		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42,567,679		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	RECONCILING ITEM		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-2011

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2019 9:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	124,172,793		124,172,793	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)	124,172,793		124,172,793	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,285,283		12,285,283	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)	12,285,283		12,285,283	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	136,458,076		136,458,076	17.00
18.00	Ancillary services	189,764,590	47,585,312	237,349,902	18.00
19.00	Outpatient services	0	1,445,196	1,445,196	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	CLINIC OP REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	326,222,666	49,030,508	375,253,174	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,501,051		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)		74,501,051		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2011

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

Worksheet G-3

Date/Time Prepared:
11/29/2019 9:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	375,253,174	1.00
2.00	Less contractual allowances and discounts on patients' accounts	305,678,192	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,574,982	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,501,051	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,926,069	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	10	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	216,731	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY RENTAL	1,128,222	24.00
24.01	NET ASSETS RELEASED	13,165	24.01
24.02	OTHER REVENUE	1,248,167	24.02
25.00	Total other income (sum of lines 6-24)	2,606,295	25.00
26.00	Total (line 5 plus line 25)	-2,319,774	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,319,774	29.00