

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: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/24/2020 11:00 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/24/2020	Time: 11:00 am
	2. ☐ Manually prepared 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 PROCTOR HOSPITAL (14-0013) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-34,714	-12,719	0	0	1.00
2.00	Subprovider - IPF	0	11	75		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
7.00	SKILLED NURSING FACILITY	0	-1	-26		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-34,704	-12,670	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: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:00 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5409 N. KNOXVILLE			PO Box:				1.00		
2.00	City: PEORIA			State: IL		Zip Code: 61614		County: PEORIA		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P
4.00	Subprovider - IPF		PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P
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		PROCTOR HOSPITAL	142337	37900		05/09/2019			
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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.					3	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	169	2	0	596	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:00 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 S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
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	46.00
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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
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.								57.00
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			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/24/2020 11:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/24/2020 11:00 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	3.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		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.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:00 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.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:00 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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	313,950 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			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	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:00 am			
1.00		2.00		3.00							
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.											
141.00	Name: PEORIA HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 00131				141.00		
142.00	Street: 221 NE GLEN OAK		PO Box:						142.00		
143.00	City: PEORIA		State: IL		Zip Code: 61636				143.00		
								1.00			
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00	
								1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N		N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00		
								1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00	
				Part A	Part B	Title V	Title XIX				
				1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)											
155.00	Hospital			N	N	N	N			155.00	
156.00	Subprovider - IPF			N	N	N	N			156.00	
157.00	Subprovider - IRF			N	N	N	N			157.00	
158.00	SUBPROVIDER									158.00	
159.00	SNF			N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00	
161.00	CMHC				N	N	N			161.00	
								1.00			
Multicampus											
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus				
		0	1.00	2.00	3.00	4.00	5.00				
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00	
								1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act											
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00	
						Beginning	Ending				
						1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00	
						1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/24/2020 11:00 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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/12/2020	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/24/2020 11:00 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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.	KEITH	LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-672-4281	KEITH.LYONS@UNITYPOINT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/24/2020 11:00 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.	SENIOR REIMBURSEMENT ANALYST		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: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	93	34,310	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)		93	34,310	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	40,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	43	15,695		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		170				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: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,294	718	11,790			1.00
2.00	HMO and other (see instructions)	3,366	0				2.00
3.00	HMO IPF Subprovider	118	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,294	718	11,790			7.00
8.00	INTENSIVE CARE UNIT	759	49	1,555			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		0	0			13.00
14.00	Total (see instructions)	7,053	767	13,345	0.00	475.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,730	0	3,976	0.00	31.86	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	6,498	0	9,661	0.00	44.54	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	551.72	27.00
28.00	Observation Bed Days		280	2,432			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			155			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	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,626	170	3,107	1.00
2.00 HMO and other (see instructions)			681	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	1,626	170	3,107	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	133	0	215	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/24/2020 11:00 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	27,998,010	0	27,998,010	1,120,091.00	25.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,158,847	-1,141,206	1,017,641	44,609.00	22.81
10.00	Excluded area salaries (see instructions)		2,593,263	250,183	2,843,446	125,858.00	22.59
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,186,085	0	3,186,085	71,537.00	44.54
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		14,558	0	14,558	116.00	125.50
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,379,902	0	8,379,902	240,704.00	34.81
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,889,310	0	8,889,310		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,967,158	0	1,967,158		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		20,091	0	20,091		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/24/2020 11:00 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	191,367	0	191,367	80.00	2,392.09	26.00
27.00	Administrative & General	5.00	879,835	0	879,835	53,482.00	16.45	27.00
28.00	Administrative & General under contract (see inst.)		441,990	0	441,990	1,718.00	257.27	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,095,905	0	1,095,905	49,674.00	22.06	30.00
31.00	Laundry & Linen Service	8.00	27,259	0	27,259	2,077.00	13.12	31.00
32.00	Housekeeping	9.00	904,778	0	904,778	61,174.00	14.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	940,047	-696,840	243,207	14,716.00	16.53	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	446,657	446,657	27,027.00	16.53	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	97,044	0	97,044	3,487.00	27.83	38.00
39.00	Central Services and Supply	14.00	393,828	0	393,828	24,077.00	16.36	39.00
40.00	Pharmacy	15.00	1,041,862	0	1,041,862	30,074.00	34.64	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/24/2020 11:00 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	28,440,000	0	28,440,000	1,121,809.00	25.35	1.00
2.00	Excluded area salaries (see instructions)	4,752,110	-891,023	3,861,087	170,467.00	22.65	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,687,890	891,023	24,578,913	951,342.00	25.84	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,580,545	0	11,580,545	312,357.00	37.07	4.00
5.00	Subtotal wage-related costs (see inst.)	8,889,310	0	8,889,310	0.00	36.17	5.00
6.00	Total (sum of lines 3 thru 5)	44,157,745	891,023	45,048,768	1,263,699.00	35.65	6.00
7.00	Total overhead cost (see instructions)	6,013,915	-250,183	5,763,732	267,586.00	21.54	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/24/2020 11:00 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,060,875	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		4,354,023	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		3,250,657	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		77,558	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,602	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		212,124	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		-11,945	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,058,352	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		93,191	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		29,250	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,126,687	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/24/2020 11:00 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/24/2020 11:00 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.157041 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,596,632 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0 5.00
6.00	Medicaid charges			51,014,993 6.00
7.00	Medicaid cost (line 1 times line 6)			8,011,446 7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			4,414,814 8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0 9.00
10.00	Stand-alone CHIP charges			0 10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0 11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0 12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0 13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0 14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0 15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0 16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0 17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0 18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			4,414,814 19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,485,020	1,468,108	3,953,128 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	390,250	1,468,108	1,858,358 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	390,250	1,468,108	1,858,358 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N 24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0 25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,516,831 26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			260,985 27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			401,514 27.01
28.00	Non-Medicare bad debt expense (see instructions)			5,115,317 28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			943,843 29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,802,201 30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,217,015 31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

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

Worksheet A

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,351,194	1,351,194	-57,549	1,293,645	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	57,549	57,549	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	191,367	35,220	226,587	-19,054	207,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	879,835	6,697,944	7,577,779	-65	7,577,714	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,887,522	1,887,522	-3	1,887,519	6.00
7.00	00700	OPERATION OF PLANT	1,095,905	2,187,012	3,282,917	-48	3,282,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,259	32,241	59,500	0	59,500	8.00
9.00	00900	HOUSEKEEPING	904,778	640,702	1,545,480	-3,984	1,541,496	9.00
10.00	01000	DIETARY	940,047	858,192	1,798,239	-1,336,705	461,534	10.00
11.00	01100	CAFETERIA	0	0	0	854,421	854,421	11.00
13.00	01300	NURSING ADMINISTRATION	97,044	22,820	119,864	0	119,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	393,828	635,102	1,028,930	-95,161	933,769	14.00
15.00	01500	PHARMACY	1,041,862	2,943,625	3,985,487	-2,675,738	1,309,749	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,434,876	3,666,019	9,100,895	-2,596,478	6,504,417	30.00
31.00	03100	INTENSIVE CARE UNIT	876,569	674,366	1,550,935	-148,510	1,402,425	31.00
40.00	04000	SUBPROVIDER - IPF	1,457,973	916,696	2,374,669	-17,771	2,356,898	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,158,847	1,814,975	3,973,822	-2,036,401	1,937,421	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,100,872	15,296,666	17,397,538	-12,603,455	4,794,083	50.00
51.00	05100	RECOVERY ROOM	1,614,282	570,769	2,185,051	-148,297	2,036,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	58,158	324,167	382,325	-200,845	181,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,704,169	1,029,867	2,734,036	-443,091	2,290,945	54.00
57.00	05700	CT SCAN	420,605	312,953	733,558	-121,047	612,511	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,225	782,457	1,032,682	-48,767	983,915	58.00
60.00	06000	LABORATORY	1,351,825	2,262,078	3,613,903	-417,692	3,196,211	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	345,722	345,722	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,050,648	1,050,648	64.00
65.00	06500	RESPIRATORY THERAPY	643,361	267,483	910,844	-57,000	853,844	65.00
66.00	06600	PHYSICAL THERAPY	0	627,090	627,090	909,273	1,536,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	788,209	788,209	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	247,602	247,602	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,502	20,587	100,089	-1,769	98,320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,359,936	5,359,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,608,503	9,608,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,972,570	2,972,570	73.00
74.00	07400	RENAL DIALYSIS	150,411	191,694	342,105	-87,439	254,666	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	44,144	44,144	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	22,067	51,849	73,916	-32,249	41,667	76.02
76.03	03140	CARDIOLOGY	475,683	699,520	1,175,203	-271,497	903,706	76.03
76.97	07697	CARDIAC REHABILITATION	398,896	119,207	518,103	-95,850	422,253	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	268,912	284,867	553,779	1,826,686	2,380,465	90.00
91.00	09100	EMERGENCY	1,823,562	1,747,106	3,570,668	-1,027,379	2,543,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,862,720	48,951,990	75,814,710	-478,581	75,336,129	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	379,153	379,153	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	714,767	356,512	1,071,279	99,428	1,170,707	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	9,011	9,011	0	9,011	194.09
194.10	07960	ARC INGALLS	420,523	244,575	665,098	0	665,098	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	27,998,010	49,562,088	77,560,098	0	77,560,098	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

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

Worksheet A

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-163,454	1,130,191	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	57,549	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,138,438	-930,905	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,040,790	20,618,504	5.00
6.00	00600	MAINTENANCE & REPAIRS	222,805	2,110,324	6.00
7.00	00700	OPERATION OF PLANT	93,338	3,376,207	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-5,984	53,516	8.00
9.00	00900	HOUSEKEEPING	0	1,541,496	9.00
10.00	01000	DIETARY	28,879	490,413	10.00
11.00	01100	CAFETERIA	0	854,421	11.00
13.00	01300	NURSING ADMINISTRATION	1,798,021	1,917,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-76,940	856,829	14.00
15.00	01500	PHARMACY	-13,964	1,295,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	623,960	623,960	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	16,343	6,520,760	30.00
31.00	03100	INTENSIVE CARE UNIT	18,896	1,421,321	31.00
40.00	04000	SUBPROVIDER - IPF	-182,027	2,174,871	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	27,926	1,965,347	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-546,672	4,247,411	50.00
51.00	05100	RECOVERY ROOM	0	2,036,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	62,720	244,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,496	2,292,441	54.00
57.00	05700	CT SCAN	153,382	765,893	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-191,802	792,113	58.00
60.00	06000	LABORATORY	-158,033	3,038,178	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	345,722	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,050,648	64.00
65.00	06500	RESPIRATORY THERAPY	0	853,844	65.00
66.00	06600	PHYSICAL THERAPY	0	1,536,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	788,209	67.00
68.00	06800	SPEECH PATHOLOGY	0	247,602	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	98,320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,359,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,608,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,972,570	73.00
74.00	07400	RENAL DIALYSIS	-53,112	201,554	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	44,144	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	12,427	54,094	76.02
76.03	03140	CARDIOLOGY	-60,820	842,886	76.03
76.97	07697	CARDIAC REHABILITATION	15,381	437,634	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	25,040	2,405,505	90.00
91.00	09100	EMERGENCY	-711,845	1,831,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,838,313	88,174,442	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	194.01
194.02	07952	MARKETING	0	0	194.02
194.03	07953	GUEST MEALS	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	379,153	194.04
194.05	07955	FOUNDATION	0	0	194.05
194.06	07956	DAYCARE CENTER	17,873	1,188,580	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	194.08
194.09	07959	ARC BROMENN	0	9,011	194.09
194.10	07960	ARC INGALLS	0	665,098	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	12,856,186	90,416,284	200.00

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:00 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	446,657	407,764		1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	198,206	180,947		2.00
3.00	DAYCARE CENTER	194.06	51,977	47,451		3.00
			696,840	636,162		
	F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,972,570		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
			0	2,972,570		
	G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,359,936		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
			0	5,359,936		
	I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,585,930		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

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:00 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
0			0	9,585,930	
J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	238,674	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	238,674	
K - COST CENTER MAPPING					
1.00	OPERATING ROOM	50.00	147,725	52,242	1.00
2.00	ANESTHESIOLOGY	53.00	6,871	2,103	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	12,906	11,291	3.00
4.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	52,139	54,909	4.00
5.00	INTRAVENOUS THERAPY	64.00	720,405	330,243	5.00
6.00	RESPIRATORY THERAPY	65.00	88,734	34,152	6.00
7.00	PHYSICAL THERAPY	66.00	686,209	484,528	7.00
8.00	OCCUPATIONAL THERAPY	67.00	357,729	430,480	8.00
9.00	SPEECH PATHOLOGY	68.00	97,267	150,335	9.00
10.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	12,040	10,533	10.00
11.00	PULMONARY FUNCTION TESTING	76.01	34,708	9,436	11.00
12.00	CARDIOLOGY	76.03	147,054	96,652	12.00
13.00	CLINIC	90.00	1,185,280	719,032	13.00
14.00		0.00	0	0	14.00
0			3,549,067	2,385,936	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	57,549	1.00
0			0	57,549	
500.00	Grand Total: Increases		4,245,907	21,236,757	500.00

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:00 am

		Decreases					8/24/2020 11:00 am	
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
		6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS								
1.00	DIETARY	10.00	696,840	636,162	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
0			696,840	636,162				
F - DRUGS RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,008	0		1.00	
2.00	OPERATION OF PLANT	7.00	0	6	0		2.00	
3.00	HOUSEKEEPING	9.00	0	8	0		3.00	
4.00	DIETARY	10.00	0	3,703	0		4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	917	0		5.00	
6.00	PHARMACY	15.00	0	2,609,543	0		6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	46,273	0		7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	11,438	0		8.00	
9.00	SUBPROVIDER - IPF	40.00	0	202	0		9.00	
10.00	SKILLED NURSING FACILITY	44.00	0	4,859	0		10.00	
11.00	OPERATING ROOM	50.00	0	44,702	0		11.00	
12.00	RECOVERY ROOM	51.00	0	46,160	0		12.00	
13.00	ANESTHESIOLOGY	53.00	0	29,016	0		13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,703	0		14.00	
15.00	CT SCAN	57.00	0	12,112	0		15.00	
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33,590	0		16.00	
17.00	LABORATORY	60.00	0	249	0		17.00	
18.00	RESPIRATORY THERAPY	65.00	0	4,754	0		18.00	
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	9	0		19.00	
20.00	RENAL DIALYSIS	74.00	0	3,665	0		20.00	
21.00	GASTRO INTESTINAL SERVICES	76.02	0	255	0		21.00	
22.00	CARDIOLOGY	76.03	0	10,119	0		22.00	
23.00	CARDIAC REHABILITATION	76.97	0	44	0		23.00	
24.00	CLINIC	90.00	0	16,149	0		24.00	
25.00	EMERGENCY	91.00	0	72,086	0		25.00	
0			0	2,972,570				
G - MED SUPPLIES RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46	0		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	65	0		2.00	
3.00	MAINTENANCE & REPAIRS	6.00	0	3	0		3.00	
4.00	OPERATION OF PLANT	7.00	0	42	0		4.00	
5.00	HOUSEKEEPING	9.00	0	3,976	0		5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	84,646	0		6.00	
7.00	PHARMACY	15.00	0	50,520	0		7.00	
8.00	ADULTS & PEDIATRICS	30.00	0	280,332	0		8.00	
9.00	INTENSIVE CARE UNIT	31.00	0	89,084	0		9.00	
10.00	SUBPROVIDER - IPF	40.00	0	17,373	0		10.00	
11.00	SKILLED NURSING FACILITY	44.00	0	83,770	0		11.00	
12.00	OPERATING ROOM	50.00	0	3,581,943	0		12.00	
13.00	RECOVERY ROOM	51.00	0	79,971	0		13.00	
14.00	ANESTHESIOLOGY	53.00	0	178,609	0		14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	245,518	0		15.00	
16.00	CT SCAN	57.00	0	104,330	0		16.00	
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	12,400	0		17.00	
18.00	LABORATORY	60.00	0	101,856	0		18.00	
19.00	RESPIRATORY THERAPY	65.00	0	86,802	0		19.00	
20.00	PHYSICAL THERAPY	66.00	0	1,919	0		20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,760	0		21.00	
22.00	RENAL DIALYSIS	74.00	0	60,454	0		22.00	
23.00	GASTRO INTESTINAL SERVICES	76.02	0	29,506	0		23.00	
24.00	CARDIOLOGY	76.03	0	60,015	0		24.00	
25.00	CARDIAC REHABILITATION	76.97	0	6,549	0		25.00	
26.00	CLINIC	90.00	0	38,364	0		26.00	
27.00	EMERGENCY	91.00	0	160,083	0		27.00	
0			0	5,359,936				
I - IMPLANTIBLE RECLASS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,598	0		1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	13,282	0		2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	10,012	0		3.00	
4.00	SUBPROVIDER - IPF	40.00	0	196	0		4.00	
5.00	SKILLED NURSING FACILITY	44.00	0	768	0		5.00	
6.00	OPERATING ROOM	50.00	0	9,100,601	0		6.00	
7.00	RECOVERY ROOM	51.00	0	22,166	0		7.00	
8.00	ANESTHESIOLOGY	53.00	0	2,194	0		8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	69,505	0		9.00	
10.00	CT SCAN	57.00	0	4,605	0		10.00	

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:00 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,777	0	11.00
12.00	RENAL DIALYSIS	74.00	0	8	0	12.00
13.00	GASTRO INTESTINAL SERVICES	76.02	0	452	0	13.00
14.00	CARDIOLOGY	76.03	0	285,650	0	14.00
15.00	CARDIAC REHABILITATION	76.97	0	702	0	15.00
16.00	CLINIC	90.00	0	23,113	0	16.00
17.00	EMERGENCY	91.00	0	40,301	0	17.00
	0		0	9,585,930		
J - BLOOD RECLASS						
1.00	PHARMACY	15.00	0	15,675	0	1.00
2.00	OPERATING ROOM	50.00	0	345	0	2.00
3.00	LABORATORY	60.00	0	222,654	0	3.00
	0		0	238,674		
K - COST CENTER MAPPING						
1.00		0.00	0	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,516,893	739,698	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	31,675	6,301	0	3.00
4.00	SKILLED NURSING FACILITY	44.00	1,141,206	805,798	0	4.00
5.00	OPERATING ROOM	50.00	29,225	46,606	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	122,366	26,196	0	6.00
7.00	LABORATORY	60.00	44,610	48,323	0	7.00
8.00	RESPIRATORY THERAPY	65.00	69,449	18,881	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	259,545	0	9.00
10.00	RENAL DIALYSIS	74.00	13,142	10,170	0	10.00
11.00	GASTRO INTESTINAL SERVICES	76.02	1,112	924	0	11.00
12.00	CARDIOLOGY	76.03	85,030	74,389	0	12.00
13.00	CARDIAC REHABILITATION	76.97	69,408	19,147	0	13.00
14.00	EMERGENCY	91.00	424,951	329,958	0	14.00
	0		3,549,067	2,385,936		
M - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,549	9	1.00
	0		0	57,549		
500.00	Grand Total: Decreases		4,245,907	21,236,757		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/24/2020 11:00 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	6,081,907	0	0	0	0	1.00
2.00	Land Improvements	6,433,463	0	0	0	0	2.00
3.00	Buildings and Fixtures	68,667,363	3,221,923	0	3,221,923	424,966	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,710,700	18,151	0	18,151	7,165	5.00
6.00	Movable Equipment	61,617,960	5,417,323	0	5,417,323	1,543,428	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,511,393	8,657,397	0	8,657,397	1,975,559	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	163,511,393	8,657,397	0	8,657,397	1,975,559	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,081,907	0				1.00
2.00	Land Improvements	6,433,463	0				2.00
3.00	Buildings and Fixtures	71,464,320	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	20,721,686	0				5.00
6.00	Movable Equipment	65,491,855	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	170,193,231	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	170,193,231	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/24/2020 11:00 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	1,351,194	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)	1,351,194	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,351,194				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,351,194				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/24/2020 11:00 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	104,701,376	0	104,701,376	0.615191	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,491,855	0	65,491,855	0.384809	0	2.00
3.00	Total (sum of lines 1-2)	170,193,231	0	170,193,231	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,293,645	39,421	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	57,549	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,351,194	39,421	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-202,875	0	0	0	1,130,191	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	57,549	2.00
3.00	Total (sum of lines 1-2)	-202,875	0	0	0	1,187,740	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

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

Worksheet A-8

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,581,539			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	16,317,560			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
19.04	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.04
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

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

Worksheet A-8

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISC REVENUE	B	-75,990	OPERATION OF PLANT	7.00	0	33.01
33.02	MISC REVENUE	B	-5,984	LAUNDRY & LINEN SERVICE	8.00	0	33.02
33.03	MISC REVENUE	B	-30,765	ADULTS & PEDIATRICS	30.00	0	33.03
33.04	MISC REVENUE	B	-2,980	CARDIOLOGY	76.03	0	33.04
33.05	MISC REVENUE	B	-259	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MISC REVENUE	B	-47,628	CARDIAC REHABILITATION	76.97	0	33.06
33.07	MISC REVENUE	B	-25,000	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.07
33.08	MISC REVENUE	B	-45,235	EMERGENCY	91.00	0	33.08
33.09	MISC REVENUE	B	-2,171	PHARMACY	15.00	0	33.09
33.10	MISC REVENUE	B	-900	LABORATORY	60.00	0	33.10
33.11	MISC REVENUE	B	-37,267	OPERATING ROOM	50.00	0	33.11
33.12	DEPR TO AHA	A	228	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	DEPR TO AHA	A	222,805	MAINTENANCE & REPAIRS	6.00	0	33.13
33.14	DEPR TO AHA	A	55,946	OPERATION OF PLANT	7.00	0	33.14
33.15	DEPR TO AHA	A	28,879	DIETARY	10.00	0	33.15
33.16	DEPR TO AHA	A	-76,940	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17	DEPR TO AHA	A	-11,793	PHARMACY	15.00	0	33.17
33.18	DEPR TO AHA	A	95,653	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	DEPR TO AHA	A	18,896	INTENSIVE CARE UNIT	31.00	0	33.19
33.20	DEPR TO AHA	A	30,364	SUBPROVIDER - IPF	40.00	0	33.20
33.21	DEPR TO AHA	A	27,926	SKILLED NURSING FACILITY	44.00	0	33.21
33.22	DEPR TO AHA	A	-236,010	OPERATING ROOM	50.00	0	33.22
33.23	DEPR TO AHA	A	69,420	ANESTHESIOLOGY	53.00	0	33.23
33.24	DEPR TO AHA	A	67,755	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	DEPR TO AHA	A	153,382	CT SCAN	57.00	0	33.25
33.26	DEPR TO AHA	A	-166,802	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.26
33.27	DEPR TO AHA	A	-77,172	LABORATORY	60.00	0	33.27
33.28	DEPR TO AHA	A	-53,080	RENAL DIALYSIS	74.00	0	33.28
33.29	DEPR TO AHA	A	12,427	GASTRO INTESTINAL SERVICES	76.02	0	33.29
33.30	DEPR TO AHA	A	-50,200	CARDIOLOGY	76.03	0	33.30
33.31	DEPR TO AHA	A	78,320	CARDIAC REHABILITATION	76.97	0	33.31
33.32	DEPR TO AHA	A	25,072	CLINIC	90.00	0	33.32
33.37	DEPR TO AHA	A	13,594	EMERGENCY	91.00	0	33.37
33.39	DEPR TO AHA	A	17,873	DAYCARE CENTER	194.06	0	33.39
33.40	ADVERTISING	A	-48,030	ADULTS & PEDIATRICS	30.00	0	33.40
33.41	ADVERTISING	A	-32	CLINIC	90.00	0	33.41
33.42	INTEREST EXPENSE	A	-133,198	CAP REL COSTS-BLDG & FIXT	1.00	11	33.42
33.43	POB SECURITY COST	A	-22,655	OPERATION OF PLANT	7.00	0	33.43
33.44	POB SECURITY COST	A	-5,664	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	SELF FUNDED INSURANCE	A	-1,682,041	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	DEPR TO AHA	A	39,421	CAP REL COSTS-BLDG & FIXT	1.00	10	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		12,856,186				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: 14-0013

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

Worksheet A-8-1

Date/Time Prepared:
8/24/2020 11:00 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	549,267	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	623,960	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,798,021	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	136,037	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	13,040,562	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	239,390	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	594,104	663,781	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,981,341	663,781	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00

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

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

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

6.00	B		100.00	UNITY POINT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0013

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

Worksheet A-8-1

Date/Time Prepared:
8/24/2020 11:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	549,267	0		1.00
2.00	623,960	0		2.00
3.00	1,798,021	0		3.00
3.01	136,037	0		3.01
4.00	13,040,562	0		4.00
4.01	239,390	0		4.01
4.02	-69,677	11		4.02
5.00	16,317,560			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	HEALTH SYSTEM		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: 14-0013

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

Worksheet A-8-2

Date/Time Prepared:
8/24/2020 11:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	239,905	239,905	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	212,391	212,391	0	181,300	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	273,750	273,375	375	246,400	3	4.00
5.00	53.00	ANESTHESIOLOGY	7,200	6,700	500	239,400	16	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	66,188	66,000	188	271,900	9	6.00
7.00	60.00	LABORATORY	80,086	79,961	125	260,300	5	7.00
8.00	74.00	RENAL DIALYSIS	32	32	0	181,300	0	8.00
9.00	76.03	CARDIOLOGY	10,995	4,595	6,400	211,500	33	9.00
10.00	76.97	CARDIAC REHABILITATION	15,311	15,311	0	211,500	0	10.00
11.00	91.00	EMERGENCY	680,454	680,204	250	211,500	3	11.00
200.00			1,586,312	1,578,474	7,838		69	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	355	18	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,841	92	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,177	59	0	0	0	6.00
7.00	60.00	LABORATORY	626	31	0	0	0	7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	0	0	8.00
9.00	76.03	CARDIOLOGY	3,355	168	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	305	15	0	0	0	11.00
200.00			7,659	383	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	239,905		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	212,391		2.00
3.00	0.00		0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	355	20	273,395		4.00
5.00	53.00	ANESTHESIOLOGY	0	1,841	0	6,700		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	1,177	0	66,000		6.00
7.00	60.00	LABORATORY	0	626	0	79,961		7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	32		8.00
9.00	76.03	CARDIOLOGY	0	3,355	3,045	7,640		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	15,311		10.00
11.00	91.00	EMERGENCY	0	305	0	680,204		11.00
200.00			0	7,659	3,065	1,581,539		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MOVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,130,191	1,130,191			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	57,549	57,549			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-930,905	37,448	1,907	-891,550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,618,504	138,134	7,034	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,110,324	175,948	8,958	0	6.00
7.00	00700	OPERATION OF PLANT	3,376,207	12,526	638	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,516	10,150	517	0	8.00
9.00	00900	HOUSEKEEPING	1,541,496	17,198	876	0	9.00
10.00	01000	DIETARY	490,413	14,418	734	0	10.00
11.00	01100	CAFETERIA	854,421	38,265	1,948	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,917,885	5,223	266	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	856,829	0	0	0	14.00
15.00	01500	PHARMACY	1,295,785	8,694	443	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	623,960	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	377	19	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,520,760	173,068	8,813	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,421,321	24,001	1,222	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,174,871	18,401	937	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,965,347	59,654	3,038	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,247,411	111,475	5,676	0	50.00
51.00	05100	RECOVERY ROOM	2,036,754	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	244,200	1,828	93	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,292,441	72,284	3,681	0	54.00
57.00	05700	CT SCAN	765,893	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	792,113	0	0	0	58.00
60.00	06000	LABORATORY	3,038,178	30,721	1,564	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	345,722	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,050,648	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	853,844	11,202	570	0	65.00
66.00	06600	PHYSICAL THERAPY	1,536,363	9,293	473	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	788,209	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	247,602	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	98,320	23,196	1,181	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,359,936	29,745	1,515	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,608,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,972,570	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	201,554	6,230	317	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	44,144	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	54,094	0	0	0	76.02
76.03	03140	CARDIOLOGY	842,886	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	437,634	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,405,505	25,414	1,294	0	90.00
91.00	09100	EMERGENCY	1,831,444	30,376	1,547	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,174,442	1,085,269	55,261	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,959	609	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	379,153	0	0	0	194.04
194.05	07955	FOUNDATION	0	7,459	380	0	194.05
194.06	07956	DAYCARE CENTER	1,188,580	24,151	1,230	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	1,353	69	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	9,011	0	0	0	194.09
194.10	07960	ARC INGALLS	665,098	0	0	0	194.10
200.00		Cross Foot Adjustments				0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
201.00		Negative Cost Centers		0	0	-891,550	-891,550	201.00
202.00		TOTAL (sum lines 118 through 201)	90,416,284	1,130,191	57,549	-891,550	90,416,284	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	20,763,672					5.00
6.00	00600	MAINTENANCE & REPAIRS	675,569	2,970,799				6.00
7.00	00700	OPERATION OF PLANT	997,614	47,792	4,434,777			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,891	38,725	58,753	180,552		8.00
9.00	00900	HOUSEKEEPING	459,038	65,614	99,550	0	2,183,772	9.00
10.00	01000	DIETARY	148,806	55,007	83,457	0	42,617	10.00
11.00	01100	CAFETERIA	263,323	145,992	221,498	0	113,108	11.00
13.00	01300	NURSING ADMINISTRATION	566,118	19,926	30,231	0	15,438	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	252,196	0	0	0	0	14.00
15.00	01500	PHARMACY	384,086	33,169	50,325	0	25,698	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	183,654	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	117	1,439	2,183	0	1,115	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,972,829	660,299	1,001,803	78,894	511,567	30.00
31.00	03100	INTENSIVE CARE UNIT	425,770	91,568	138,927	10,405	70,943	31.00
40.00	04000	SUBPROVIDER - IPF	645,835	70,203	106,512	26,606	54,390	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	596,925	227,597	345,310	64,647	176,332	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,284,648	425,306	645,272	0	329,507	50.00
51.00	05100	RECOVERY ROOM	599,490	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	72,442	6,974	10,581	0	5,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	697,107	275,781	418,415	0	213,662	54.00
57.00	05700	CT SCAN	225,430	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	233,147	0	0	0	0	58.00
60.00	06000	LABORATORY	903,748	117,210	177,831	0	90,809	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	101,758	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	309,244	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	254,782	42,740	64,845	0	33,113	65.00
66.00	06600	PHYSICAL THERAPY	455,081	35,454	53,790	0	27,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	231,998	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	72,878	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,114	88,499	134,270	0	68,565	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,823	113,487	172,182	0	87,924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,828,114	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	874,934	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	61,252	23,770	36,064	0	18,416	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	12,993	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	15,922	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	248,092	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	128,811	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	715,888	96,962	147,111	0	75,122	90.00
91.00	09100	EMERGENCY	548,456	115,892	175,831	0	89,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,089,923	2,799,406	4,174,741	180,552	2,050,985	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,699	45,628	69,227	0	35,351	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	111,598	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,307	28,460	43,179	0	22,049	194.05
194.06	07956	DAYCARE CENTER	357,312	92,142	139,797	0	71,387	194.06
194.07	07957	UN-USED SQR FT - POB	419	5,163	7,833	0	4,000	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	2,652	0	0	0	0	194.09
194.10	07960	ARC INGALLS	195,762	0	0	0	0	194.10
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)	20,763,672	2,970,799	4,434,777	180,552	2,183,772	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	835,452					10.00
11.00	01100	CAFETERIA	0	1,638,555				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,155	2,562,242			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,035	0	1,138,060		14.00
15.00	01500	PHARMACY	0	76,811	0	0	1,875,011	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	365,057	377,492	786,229	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	48,148	86,138	179,408	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	123,110	127,208	264,948	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	299,137	81,736	170,239	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	163,623	340,794	0	0	50.00
51.00	05100	RECOVERY ROOM	0	119,013	247,879	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,794	9,985	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,570	244,874	0	0	54.00
57.00	05700	CT SCAN	0	31,009	64,586	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	18,448	38,423	0	0	58.00
60.00	06000	LABORATORY	0	96,374	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	3,844	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	53,112	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	48,854	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	50,591	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,374	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,171	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	408,065	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	729,995	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,875,011	73.00
74.00	07400	RENAL DIALYSIS	0	9,036	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	103,167	214,877	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	835,452	1,638,555	2,562,242	1,138,060	1,875,011	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	835,452	1,638,555	2,562,242	1,138,060	1,875,011	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
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	807,614					16.00
17.00	01700	SOCIAL SERVICE	0	5,250				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,508	2,293	12,512,612	0	12,512,612	30.00
31.00	03100	INTENSIVE CARE UNIT	11,292	303	2,509,446	0	2,509,446	31.00
40.00	04000	SUBPROVIDER - IPF	13,666	774	3,627,461	0	3,627,461	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	12,957	1,880	4,004,799	0	4,004,799	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	162,860	0	7,716,572	0	7,716,572	50.00
51.00	05100	RECOVERY ROOM	33,523	0	3,036,659	0	3,036,659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	46,711	0	403,011	0	403,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,500	0	4,370,315	0	4,370,315	54.00
57.00	05700	CT SCAN	54,727	0	1,141,645	0	1,141,645	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,488	0	1,104,619	0	1,104,619	58.00
60.00	06000	LABORATORY	51,680	0	4,508,115	0	4,508,115	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,018	0	453,342	0	453,342	63.00
64.00	06400	INTRAVENOUS THERAPY	16,212	0	1,429,216	0	1,429,216	64.00
65.00	06500	RESPIRATORY THERAPY	18,502	0	1,328,452	0	1,328,452	65.00
66.00	06600	PHYSICAL THERAPY	11,915	0	2,180,428	0	2,180,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,164	0	1,051,745	0	1,051,745	67.00
68.00	06800	SPEECH PATHOLOGY	1,856	0	329,507	0	329,507	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	342	0	450,487	0	450,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,909	0	7,814,586	0	7,814,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,434	0	13,218,046	0	13,218,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,556	0	5,764,071	0	5,764,071	73.00
74.00	07400	RENAL DIALYSIS	1,829	0	358,468	0	358,468	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,556	0	58,693	0	58,693	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	3,957	0	73,973	0	73,973	76.02
76.03	03140	CARDIOLOGY	23,063	0	1,114,041	0	1,114,041	76.03
76.97	07697	CARDIAC REHABILITATION	1,840	0	568,285	0	568,285	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	22,494	0	3,489,790	0	3,489,790	90.00
91.00	09100	EMERGENCY	51,055	0	3,162,433	0	3,162,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	807,614	5,250	87,780,817	0	87,780,817	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	166,473	0	166,473	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	490,751	0	490,751	194.04
194.05	07955	FOUNDATION	0	0	103,834	0	103,834	194.05
194.06	07956	DAYCARE CENTER	0	0	1,874,599	0	1,874,599	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	18,837	0	18,837	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	11,663	0	11,663	194.09
194.10	07960	ARC INGALLS	0	0	860,860	0	860,860	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-891,550	0	-891,550	201.00
202.00		TOTAL (sum lines 118 through 201)	807,614	5,250	90,416,284	0	90,416,284	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/24/2020 11:00 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	6,171	37,448	1,907	45,526	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,157	138,134	7,034	164,325	5.00
6.00	00600	MAINTENANCE & REPAIRS	798,523	175,948	8,958	983,429	6.00
7.00	00700	OPERATION OF PLANT	171,443	12,526	638	184,607	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,150	517	10,667	8.00
9.00	00900	HOUSEKEEPING	11,490	17,198	876	29,564	9.00
10.00	01000	DIETARY	0	14,418	734	15,152	10.00
11.00	01100	CAFETERIA	0	38,265	1,948	40,213	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,223	266	5,489	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,387	0	0	131,387	14.00
15.00	01500	PHARMACY	59,214	8,694	443	68,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	377	19	396	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	140,728	173,068	8,813	322,609	30.00
31.00	03100	INTENSIVE CARE UNIT	75,743	24,001	1,222	100,966	31.00
40.00	04000	SUBPROVIDER - IPF	83,830	18,401	937	103,168	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	86,021	59,654	3,038	148,713	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	409,687	111,475	5,676	526,838	50.00
51.00	05100	RECOVERY ROOM	18,721	0	0	18,721	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	153,358	1,828	93	155,279	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,486	72,284	3,681	342,451	54.00
57.00	05700	CT SCAN	239,659	0	0	239,659	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	416,590	0	0	416,590	58.00
60.00	06000	LABORATORY	35,079	30,721	1,564	67,364	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,575	0	0	4,575	63.00
64.00	06400	INTRAVENOUS THERAPY	49,567	0	0	49,567	64.00
65.00	06500	RESPIRATORY THERAPY	47,183	11,202	570	58,955	65.00
66.00	06600	PHYSICAL THERAPY	54,882	9,293	473	64,648	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,248	0	0	28,248	67.00
68.00	06800	SPEECH PATHOLOGY	7,850	0	0	7,850	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	366	23,196	1,181	24,743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,745	1,515	31,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,402	0	0	5,402	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	6,230	317	6,547	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,775	0	0	1,775	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	21,685	0	0	21,685	76.02
76.03	03140	CARDIOLOGY	142,195	0	0	142,195	76.03
76.97	07697	CARDIAC REHABILITATION	76,097	0	0	76,097	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	232,931	25,414	1,294	259,639	90.00
91.00	09100	EMERGENCY	163,257	30,376	1,547	195,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,959,300	1,085,269	55,261	5,099,830	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,959	609	12,568	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	7,459	380	7,839	194.05
194.06	07956	DAYCARE CENTER	18,753	24,151	1,230	44,134	194.06
194.07	07957	UN-USED SQR FT - POB	0	1,353	69	1,422	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	3,978,053	1,130,191	57,549	5,165,793	45,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	164,325					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,346	988,775				6.00
7.00	00700	OPERATION OF PLANT	7,894	15,907	208,408			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	149	12,889	2,761	26,466		8.00
9.00	00900	HOUSEKEEPING	3,632	21,838	4,678	0	59,712	9.00
10.00	01000	DIETARY	1,177	18,308	3,922	0	1,165	10.00
11.00	01100	CAFETERIA	2,084	48,591	10,409	0	3,093	11.00
13.00	01300	NURSING ADMINISTRATION	4,480	6,632	1,421	0	422	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,996	0	0	0	0	14.00
15.00	01500	PHARMACY	3,039	11,040	2,365	0	703	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,453	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1	479	103	0	30	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,610	219,770	47,078	11,565	13,988	30.00
31.00	03100	INTENSIVE CARE UNIT	3,369	30,477	6,529	1,525	1,940	31.00
40.00	04000	SUBPROVIDER - IPF	5,110	23,366	5,005	3,900	1,487	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,723	75,751	16,228	9,476	4,822	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,165	141,555	30,324	0	9,010	50.00
51.00	05100	RECOVERY ROOM	4,744	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	573	2,321	497	0	148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,516	91,789	19,663	0	5,842	54.00
57.00	05700	CT SCAN	1,784	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,845	0	0	0	0	58.00
60.00	06000	LABORATORY	7,151	39,011	8,357	0	2,483	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	805	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,447	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,016	14,225	3,047	0	905	65.00
66.00	06600	PHYSICAL THERAPY	3,601	11,800	2,528	0	751	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,836	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	577	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	286	29,455	6,310	0	1,875	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,556	37,772	8,092	0	2,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,406	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,923	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	485	7,911	1,695	0	504	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	103	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	126	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	1,963	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,019	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,665	32,272	6,913	0	2,054	90.00
91.00	09100	EMERGENCY	4,340	38,572	8,263	0	2,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,995	931,731	196,188	26,466	56,081	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29	15,186	3,253	0	967	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	883	0	0	0	0	194.04
194.05	07955	FOUNDATION	18	9,472	2,029	0	603	194.05
194.06	07956	DAYCARE CENTER	2,827	30,668	6,570	0	1,952	194.06
194.07	07957	UN-USED SQR FT - POB	3	1,718	368	0	109	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	21	0	0	0	0	194.09
194.10	07960	ARC INGALLS	1,549	0	0	0	0	194.10
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)	164,325	988,775	208,408	26,466	59,712	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	39,724					10.00
11.00	01100	CAFETERIA	0	104,390				11.00
13.00	01300	NURSING ADMINISTRATION	0	456	18,900			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,850	0	135,233		14.00
15.00	01500	PHARMACY	0	4,894	0	0	90,392	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,358	24,049	5,794	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,289	5,488	1,324	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,854	8,104	1,955	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,223	5,207	1,256	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,424	2,515	0	0	50.00
51.00	05100	RECOVERY ROOM	0	7,582	1,829	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	305	74	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,490	1,807	0	0	54.00
57.00	05700	CT SCAN	0	1,976	477	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,175	284	0	0	58.00
60.00	06000	LABORATORY	0	6,140	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	245	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,384	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,112	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,223	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,680	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	457	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	48,489	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	86,744	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	90,392	73.00
74.00	07400	RENAL DIALYSIS	0	576	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	6,573	1,585	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,724	104,390	18,900	135,233	90,392	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	39,724	104,390	18,900	135,233	90,392	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,453					16.00
17.00	01700	SOCIAL SERVICE	0	1,009				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111	441	678,373	0	678,373	30.00
31.00	03100	INTENSIVE CARE UNIT	23	58	153,988	0	153,988	31.00
40.00	04000	SUBPROVIDER - IPF	28	149	158,126	0	158,126	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	27	361	280,787	0	280,787	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	113	0	730,944	0	730,944	50.00
51.00	05100	RECOVERY ROOM	70	0	32,946	0	32,946	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	97	0	159,294	0	159,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72	0	474,630	0	474,630	54.00
57.00	05700	CT SCAN	114	0	244,010	0	244,010	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47	0	419,941	0	419,941	58.00
60.00	06000	LABORATORY	107	0	130,613	0	130,613	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4	0	5,629	0	5,629	63.00
64.00	06400	INTRAVENOUS THERAPY	34	0	55,432	0	55,432	64.00
65.00	06500	RESPIRATORY THERAPY	38	0	82,298	0	82,298	65.00
66.00	06600	PHYSICAL THERAPY	25	0	86,576	0	86,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	11	0	31,775	0	31,775	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	8,888	0	8,888	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1	0	62,670	0	62,670	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114	0	140,687	0	140,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107	0	114,659	0	114,659	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86	0	97,401	0	97,401	73.00
74.00	07400	RENAL DIALYSIS	4	0	17,722	0	17,722	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	3	0	1,881	0	1,881	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	8	0	21,819	0	21,819	76.02
76.03	03140	CARDIOLOGY	48	0	144,206	0	144,206	76.03
76.97	07697	CARDIAC REHABILITATION	4	0	77,120	0	77,120	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	47	0	306,590	0	306,590	90.00
91.00	09100	EMERGENCY	106	0	257,074	0	257,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,453	1,009	4,976,079	0	4,976,079	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	32,003	0	32,003	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	883	0	883	194.04
194.05	07955	FOUNDATION	0	0	19,961	0	19,961	194.05
194.06	07956	DAYCARE CENTER	0	0	86,151	0	86,151	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	3,620	0	3,620	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	21	0	21	194.09
194.10	07960	ARC INGALLS	0	0	1,549	0	1,549	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	45,526	0	45,526	201.00
202.00		TOTAL (sum lines 118 through 201)	1,453	1,009	5,165,793	0	5,165,793	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	428,474				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		428,474			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,197	14,197	29,676,827		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,369	52,369	879,835	-20,763,672	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,095,905	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	27,259	0	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	904,778	0	9.00
10.00	01000	DIETARY	5,466	5,466	243,207	0	10.00
11.00	01100	CAFETERIA	14,507	14,507	446,657	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	97,044	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	393,828	0	14.00
15.00	01500	PHARMACY	3,296	3,296	1,041,862	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	5,120,166	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,168,371	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	1,725,440	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	1,108,661	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	42,262	42,262	2,219,373	0	50.00
51.00	05100	RECOVERY ROOM	0	0	1,614,282	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	65,029	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,594,709	0	54.00
57.00	05700	CT SCAN	0	0	420,605	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	250,225	0	58.00
60.00	06000	LABORATORY	11,647	11,647	1,307,215	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	52,139	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	720,405	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	662,645	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	686,209	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	357,729	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	97,267	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	79,502	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,040	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,362	2,362	122,562	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	34,708	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	20,955	0	76.02
76.03	03140	CARDIOLOGY	0	0	537,707	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	329,488	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,635	9,635	1,454,192	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,399,355	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	411,443	411,443	28,291,354	-20,763,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	198,206	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	766,744	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	420,523	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,130,191	57,549	-891,550		20,763,672	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.637712	0.134312	0.000000		0.294336	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			45,526		164,325	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001534		0.002329	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: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	295,204					6.00
7.00	00700	OPERATION OF PLANT	4,749	290,455				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	26,982			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	280,087		9.00
10.00	01000	DIETARY	5,466	5,466	0	5,466	26,982	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	0	1,980	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	11,790	65,613	11,790	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,555	9,099	1,555	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,976	6,976	3,976	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	9,661	22,616	9,661	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	0	3,523	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	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	2,362	2,362	0	2,362	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,173	273,424	26,982	263,056	26,982	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	2,970,799	4,434,777	180,552	2,183,772	835,452	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	10.063546	15.268379	6.691572	7.796763	30.963309	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	988,775	208,408	26,466	59,712	39,724	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.349463	0.717523	0.980876	0.213191	1.472241	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: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	22,225,121					11.00
13.00	01300	NURSING ADMINISTRATION	97,044	16,686,216				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	393,828	0	14,944,415			14.00
15.00	01500	PHARMACY	1,041,862	0	0	2,972,570		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	558,968,182	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,120,166	5,120,166	0	0	37,029,441	30.00
31.00	03100	INTENSIVE CARE UNIT	1,168,371	1,168,371	0	0	7,814,781	31.00
40.00	04000	SUBPROVIDER - IPF	1,725,440	1,725,440	0	0	9,457,456	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,108,661	1,108,661	0	0	8,966,676	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,219,373	2,219,373	0	0	112,772,374	50.00
51.00	05100	RECOVERY ROOM	1,614,282	1,614,282	0	0	23,199,155	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	65,029	65,029	0	0	32,325,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,594,709	1,594,709	0	0	23,875,629	54.00
57.00	05700	CT SCAN	420,605	420,605	0	0	37,873,310	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,225	250,225	0	0	15,562,668	58.00
60.00	06000	LABORATORY	1,307,215	0	0	0	35,765,051	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	52,139	0	0	0	1,396,544	63.00
64.00	06400	INTRAVENOUS THERAPY	720,405	0	0	0	11,219,044	64.00
65.00	06500	RESPIRATORY THERAPY	662,645	0	0	0	12,804,315	65.00
66.00	06600	PHYSICAL THERAPY	686,209	0	0	0	8,245,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	357,729	0	0	0	3,573,442	67.00
68.00	06800	SPEECH PATHOLOGY	97,267	0	0	0	1,284,755	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	236,368	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,358,485	0	37,998,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,585,930	0	35,594,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,972,570	28,758,512	73.00
74.00	07400	RENAL DIALYSIS	122,562	0	0	0	1,265,689	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	1,076,774	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	2,738,571	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	15,960,259	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,273,418	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	15,566,726	90.00
91.00	09100	EMERGENCY	1,399,355	1,399,355	0	0	35,331,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,225,121	16,686,216	14,944,415	2,972,570	558,968,182	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,638,555	2,562,242	1,138,060	1,875,011	807,614	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.073725	0.153554	0.076153	0.630771	0.001445	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	104,390	18,900	135,233	90,392	1,453	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004697	0.001133	0.009049	0.030409	0.000003	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: 14-0013

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

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
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
		26,982	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		11,790	
		1,555	
		3,976	
		0	
		9,661	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	ANCILLARY	76.00
76.01	03560	PULMONARY FUNCTION TESTING	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	76.02
76.03	03140	CARDIOLOGY	76.03
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	194.00
194.01	07951	MEALS ON WHEELS	194.01
194.02	07952	MARKETING	194.02
194.03	07953	GUEST MEALS	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	194.04
194.05	07955	FOUNDATION	194.05
194.06	07956	DAYCARE CENTER	194.06
194.07	07957	UN-USED SQR FT - POB	194.07
194.08	07958	SENIOR SERVICES	194.08
194.09	07959	ARC BROMENN	194.09
194.10	07960	ARC INGALLS	194.10
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)	202.00
		5,250	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE		
		(PATIENT DAYS)		
		17.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	0.194574		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,009		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.037395		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2020 11:00 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,512,612		12,512,612	0		12,512,612	30.00
31.00	03100	INTENSIVE CARE UNIT	2,509,446		2,509,446	0		2,509,446	31.00
40.00	04000	SUBPROVIDER - IPF	3,627,461		3,627,461	0		3,627,461	40.00
43.00	04300	NURSERY	0		0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,004,799		4,004,799	0		4,004,799	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,716,572		7,716,572	20		7,716,592	50.00
51.00	05100	RECOVERY ROOM	3,036,659		3,036,659	0		3,036,659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0		0	52.00
53.00	05300	ANESTHESIOLOGY	403,011		403,011	0		403,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,370,315		4,370,315	0		4,370,315	54.00
57.00	05700	CT SCAN	1,141,645		1,141,645	0		1,141,645	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,104,619		1,104,619	0		1,104,619	58.00
60.00	06000	LABORATORY	4,508,115		4,508,115	0		4,508,115	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	453,342		453,342	0		453,342	63.00
64.00	06400	INTRAVENOUS THERAPY	1,429,216		1,429,216	0		1,429,216	64.00
65.00	06500	RESPIRATORY THERAPY	1,328,452	0	1,328,452	0		1,328,452	65.00
66.00	06600	PHYSICAL THERAPY	2,180,428	0	2,180,428	0		2,180,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,051,745	0	1,051,745	0		1,051,745	67.00
68.00	06800	SPEECH PATHOLOGY	329,507	0	329,507	0		329,507	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	450,487		450,487	0		450,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,814,586		7,814,586	0		7,814,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,218,046		13,218,046	0		13,218,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,764,071		5,764,071	0		5,764,071	73.00
74.00	07400	RENAL DIALYSIS	358,468		358,468	0		358,468	74.00
76.00	03950	ANCILLARY	0		0	0		0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	58,693		58,693	0		58,693	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	73,973		73,973	0		73,973	76.02
76.03	03140	CARDIOLOGY	1,114,041		1,114,041	3,045		1,117,086	76.03
76.97	07697	CARDIAC REHABILITATION	568,285		568,285	0		568,285	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,489,790		3,489,790	0		3,489,790	90.00
91.00	09100	EMERGENCY	3,162,433		3,162,433	0		3,162,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,139,698		2,139,698			2,139,698	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0			0	101.00
200.00		Subtotal (see instructions)	89,920,515	0	89,920,515	3,065		89,923,580	200.00
201.00		Less Observation Beds	2,139,698		2,139,698			2,139,698	201.00
202.00		Total (see instructions)	87,780,817	0	87,780,817	3,065		87,783,882	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,023,214		33,023,214			30.00
31.00	03100	INTENSIVE CARE UNIT	7,814,781		7,814,781			31.00
40.00	04000	SUBPROVIDER - IPF	9,457,456		9,457,456			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	8,966,676		8,966,676			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,946,180	95,826,194	112,772,374	0.068426	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,841,002	19,358,153	23,199,155	0.130895	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,382,320	27,943,361	32,325,681	0.012467	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,874,300	19,001,329	23,875,629	0.183045	0.000000	54.00
57.00	05700	CT SCAN	8,562,153	29,311,157	37,873,310	0.030144	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,848,403	13,714,265	15,562,668	0.070979	0.000000	58.00
60.00	06000	LABORATORY	14,082,197	21,682,854	35,765,051	0.126048	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	923,308	473,236	1,396,544	0.324617	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,493,295	8,725,749	11,219,044	0.127392	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,669,704	1,134,611	12,804,315	0.103750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,444,733	801,148	8,245,881	0.264426	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,506,181	67,261	3,573,442	0.294323	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,166,886	117,869	1,284,755	0.256475	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122,555	113,813	236,368	1.905871	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,428,785	27,570,187	37,998,972	0.205653	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,219,972	23,374,741	35,594,713	0.371349	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,293,626	16,464,886	28,758,512	0.200430	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	1,265,689	1,265,689	0.283220	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	356,221	720,553	1,076,774	0.054508	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,200,327	1,538,244	2,738,571	0.027012	0.000000	76.02
76.03	03140	CARDIOLOGY	7,516,400	8,443,859	15,960,259	0.069801	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	245	1,273,173	1,273,418	0.446267	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,969,880	13,596,846	15,566,726	0.224183	0.000000	90.00
91.00	09100	EMERGENCY	7,266,659	28,065,318	35,331,977	0.089506	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	561,090	3,445,137	4,006,227	0.534093	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	194,938,549	364,029,633	558,968,182			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	194,938,549	364,029,633	558,968,182			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/24/2020 11:00 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.068426		50.00
51.00	05100	RECOVERY ROOM	0.130895		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.012467		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045		54.00
57.00	05700	CT SCAN	0.030144		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979		58.00
60.00	06000	LABORATORY	0.126048		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617		63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392		64.00
65.00	06500	RESPIRATORY THERAPY	0.103750		65.00
66.00	06600	PHYSICAL THERAPY	0.264426		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323		67.00
68.00	06800	SPEECH PATHOLOGY	0.256475		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430		73.00
74.00	07400	RENAL DIALYSIS	0.283220		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012		76.02
76.03	03140	CARDIOLOGY	0.069992		76.03
76.97	07697	CARDIAC REHABILITATION	0.446267		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.224183		90.00
91.00	09100	EMERGENCY	0.089506		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2020 11:00 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,512,612		12,512,612	0	12,512,612	30.00
31.00	03100	INTENSIVE CARE UNIT	2,509,446		2,509,446	0	2,509,446	31.00
40.00	04000	SUBPROVIDER - IPF	3,627,461		3,627,461	0	3,627,461	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,004,799		4,004,799	0	4,004,799	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,716,572		7,716,572	20	7,716,592	50.00
51.00	05100	RECOVERY ROOM	3,036,659		3,036,659	0	3,036,659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	403,011		403,011	0	403,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,370,315		4,370,315	0	4,370,315	54.00
57.00	05700	CT SCAN	1,141,645		1,141,645	0	1,141,645	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,104,619		1,104,619	0	1,104,619	58.00
60.00	06000	LABORATORY	4,508,115		4,508,115	0	4,508,115	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	453,342		453,342	0	453,342	63.00
64.00	06400	INTRAVENOUS THERAPY	1,429,216		1,429,216	0	1,429,216	64.00
65.00	06500	RESPIRATORY THERAPY	1,328,452	0	1,328,452	0	1,328,452	65.00
66.00	06600	PHYSICAL THERAPY	2,180,428	0	2,180,428	0	2,180,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,051,745	0	1,051,745	0	1,051,745	67.00
68.00	06800	SPEECH PATHOLOGY	329,507	0	329,507	0	329,507	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	450,487		450,487	0	450,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,814,586		7,814,586	0	7,814,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,218,046		13,218,046	0	13,218,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,764,071		5,764,071	0	5,764,071	73.00
74.00	07400	RENAL DIALYSIS	358,468		358,468	0	358,468	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	58,693		58,693	0	58,693	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	73,973		73,973	0	73,973	76.02
76.03	03140	CARDIOLOGY	1,114,041		1,114,041	3,045	1,117,086	76.03
76.97	07697	CARDIAC REHABILITATION	568,285		568,285	0	568,285	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,489,790		3,489,790	0	3,489,790	90.00
91.00	09100	EMERGENCY	3,162,433		3,162,433	0	3,162,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,139,698		2,139,698		2,139,698	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	89,920,515	0	89,920,515	3,065	89,923,580	200.00
201.00		Less Observation Beds	2,139,698		2,139,698		2,139,698	201.00
202.00		Total (see instructions)	87,780,817	0	87,780,817	3,065	87,783,882	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2020 11:00 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,023,214		33,023,214		30.00
31.00	03100	INTENSIVE CARE UNIT	7,814,781		7,814,781		31.00
40.00	04000	SUBPROVIDER - IPF	9,457,456		9,457,456		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	8,966,676		8,966,676		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,946,180	95,826,194	112,772,374	0.068426	0.000000
51.00	05100	RECOVERY ROOM	3,841,002	19,358,153	23,199,155	0.130895	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	4,382,320	27,943,361	32,325,681	0.012467	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,874,300	19,001,329	23,875,629	0.183045	0.000000
57.00	05700	CT SCAN	8,562,153	29,311,157	37,873,310	0.030144	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,848,403	13,714,265	15,562,668	0.070979	0.000000
60.00	06000	LABORATORY	14,082,197	21,682,854	35,765,051	0.126048	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	923,308	473,236	1,396,544	0.324617	0.000000
64.00	06400	INTRAVENOUS THERAPY	2,493,295	8,725,749	11,219,044	0.127392	0.000000
65.00	06500	RESPIRATORY THERAPY	11,669,704	1,134,611	12,804,315	0.103750	0.000000
66.00	06600	PHYSICAL THERAPY	7,444,733	801,148	8,245,881	0.264426	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,506,181	67,261	3,573,442	0.294323	0.000000
68.00	06800	SPEECH PATHOLOGY	1,166,886	117,869	1,284,755	0.256475	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	122,555	113,813	236,368	1.905871	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,428,785	27,570,187	37,998,972	0.205653	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,219,972	23,374,741	35,594,713	0.371349	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	12,293,626	16,464,886	28,758,512	0.200430	0.000000
74.00	07400	RENAL DIALYSIS	0	1,265,689	1,265,689	0.283220	0.000000
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000
76.01	03560	PULMONARY FUNCTION TESTING	356,221	720,553	1,076,774	0.054508	0.000000
76.02	03340	GASTRO INTESTINAL SERVICES	1,200,327	1,538,244	2,738,571	0.027012	0.000000
76.03	03140	CARDIOLOGY	7,516,400	8,443,859	15,960,259	0.069801	0.000000
76.97	07697	CARDIAC REHABILITATION	245	1,273,173	1,273,418	0.446267	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,969,880	13,596,846	15,566,726	0.224183	0.000000
91.00	09100	EMERGENCY	7,266,659	28,065,318	35,331,977	0.089506	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	561,090	3,445,137	4,006,227	0.534093	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	194,938,549	364,029,633	558,968,182		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	194,938,549	364,029,633	558,968,182		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2020 11:00 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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.068426		50.00
51.00	05100	RECOVERY ROOM	0.130895		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.012467		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045		54.00
57.00	05700	CT SCAN	0.030144		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979		58.00
60.00	06000	LABORATORY	0.126048		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617		63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392		64.00
65.00	06500	RESPIRATORY THERAPY	0.103750		65.00
66.00	06600	PHYSICAL THERAPY	0.264426		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323		67.00
68.00	06800	SPEECH PATHOLOGY	0.256475		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430		73.00
74.00	07400	RENAL DIALYSIS	0.283220		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012		76.02
76.03	03140	CARDIOLOGY	0.069992		76.03
76.97	07697	CARDIAC REHABILITATION	0.446267		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.224183		90.00
91.00	09100	EMERGENCY	0.089506		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0013

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

Worksheet C
Part II
Date/Time Prepared:
8/24/2020 11:00 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	7,716,572	730,944	6,985,628	0	0
51.00	05100	RECOVERY ROOM	3,036,659	32,946	3,003,713	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	403,011	159,294	243,717	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,370,315	474,630	3,895,685	0	0
57.00	05700	CT SCAN	1,141,645	244,010	897,635	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,104,619	419,941	684,678	0	0
60.00	06000	LABORATORY	4,508,115	130,613	4,377,502	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	453,342	5,629	447,713	0	0
64.00	06400	INTRAVENOUS THERAPY	1,429,216	55,432	1,373,784	0	0
65.00	06500	RESPIRATORY THERAPY	1,328,452	82,298	1,246,154	0	0
66.00	06600	PHYSICAL THERAPY	2,180,428	86,576	2,093,852	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,051,745	31,775	1,019,970	0	0
68.00	06800	SPEECH PATHOLOGY	329,507	8,888	320,619	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	450,487	62,670	387,817	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,814,586	140,687	7,673,899	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,218,046	114,659	13,103,387	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,764,071	97,401	5,666,670	0	0
74.00	07400	RENAL DIALYSIS	358,468	17,722	340,746	0	0
76.00	03950	ANCILLARY	0	0	0	0	0
76.01	03560	PULMONARY FUNCTION TESTING	58,693	1,881	56,812	0	0
76.02	03340	GASTRO INTESTINAL SERVICES	73,973	21,819	52,154	0	0
76.03	03140	CARDIOLOGY	1,114,041	144,206	969,835	0	0
76.97	07697	CARDIAC REHABILITATION	568,285	77,120	491,165	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,489,790	306,590	3,183,200	0	0
91.00	09100	EMERGENCY	3,162,433	257,074	2,905,359	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,139,698	116,004	2,023,694	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	67,266,197	3,820,809	63,445,388	0	0
201.00		Less Observation Beds	2,139,698	116,004	2,023,694	0	0
202.00		Total (line 200 minus line 201)	65,126,499	3,704,805	61,421,694	0	0

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

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description			Title XIX		Hospital	PPS
			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	7,716,572	112,772,374	0.068426	50.00
51.00	05100	RECOVERY ROOM	3,036,659	23,199,155	0.130895	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	403,011	32,325,681	0.012467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,370,315	23,875,629	0.183045	54.00
57.00	05700	CT SCAN	1,141,645	37,873,310	0.030144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,104,619	15,562,668	0.070979	58.00
60.00	06000	LABORATORY	4,508,115	35,765,051	0.126048	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	453,342	1,396,544	0.324617	63.00
64.00	06400	INTRAVENOUS THERAPY	1,429,216	11,219,044	0.127392	64.00
65.00	06500	RESPIRATORY THERAPY	1,328,452	12,804,315	0.103750	65.00
66.00	06600	PHYSICAL THERAPY	2,180,428	8,245,881	0.264426	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,051,745	3,573,442	0.294323	67.00
68.00	06800	SPEECH PATHOLOGY	329,507	1,284,755	0.256475	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	450,487	236,368	1.905871	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,814,586	37,998,972	0.205653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,218,046	35,594,713	0.371349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,764,071	28,758,512	0.200430	73.00
74.00	07400	RENAL DIALYSIS	358,468	1,265,689	0.283220	74.00
76.00	03950	ANCILLARY	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	58,693	1,076,774	0.054508	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	73,973	2,738,571	0.027012	76.02
76.03	03140	CARDIOLOGY	1,114,041	15,960,259	0.069801	76.03
76.97	07697	CARDIAC REHABILITATION	568,285	1,273,418	0.446267	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,489,790	15,566,726	0.224183	90.00
91.00	09100	EMERGENCY	3,162,433	35,331,977	0.089506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,139,698	4,006,227	0.534093	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
200.00		Subtotal (sum of lines 50 thru 199)	67,266,197	499,706,055		200.00
201.00		Less Observation Beds	2,139,698	0		201.00
202.00		Total (line 200 minus line 201)	65,126,499	499,706,055		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Title XVIII			Hospital		PPS			
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	678,373	0	678,373	14,222	47.70	30.00	
31.00	INTENSIVE CARE UNIT	153,988		153,988	1,555	99.03	31.00	
40.00	SUBPROVIDER - IPF	158,126	0	158,126	3,976	39.77	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	280,787		280,787	9,661	29.06	44.00	
200.00	Total (lines 30 through 199)	1,271,274		1,271,274	29,414		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,294	300,224					30.00
31.00	INTENSIVE CARE UNIT	759	75,164					31.00
40.00	SUBPROVIDER - IPF	2,730	108,572					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	6,498	188,832					44.00
200.00	Total (lines 30 through 199)	16,281	672,792					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/24/2020 11:00 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	730,944	112,772,374	0.006482	8,030,386	52,053	50.00
51.00	05100	RECOVERY ROOM	32,946	23,199,155	0.001420	1,726,826	2,452	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	159,294	32,325,681	0.004928	2,030,269	10,005	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,630	23,875,629	0.019879	2,430,714	48,320	54.00
57.00	05700	CT SCAN	244,010	37,873,310	0.006443	4,419,961	28,478	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	419,941	15,562,668	0.026984	955,463	25,782	58.00
60.00	06000	LABORATORY	130,613	35,765,051	0.003652	6,500,391	23,739	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5,629	1,396,544	0.004031	422,036	1,701	63.00
64.00	06400	INTRAVENOUS THERAPY	55,432	11,219,044	0.004941	1,273,046	6,290	64.00
65.00	06500	RESPIRATORY THERAPY	82,298	12,804,315	0.006427	4,407,810	28,329	65.00
66.00	06600	PHYSICAL THERAPY	86,576	8,245,881	0.010499	962,974	10,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,775	3,573,442	0.008892	303,181	2,696	67.00
68.00	06800	SPEECH PATHOLOGY	8,888	1,284,755	0.006918	186,346	1,289	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,670	236,368	0.265137	43,876	11,633	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,687	37,998,972	0.003702	5,342,439	19,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,659	35,594,713	0.003221	6,062,998	19,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,401	28,758,512	0.003387	5,090,805	17,243	73.00
74.00	07400	RENAL DIALYSIS	17,722	1,265,689	0.014002	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,881	1,076,774	0.001747	201,103	351	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	21,819	2,738,571	0.007967	543,451	4,330	76.02
76.03	03140	CARDIOLOGY	144,206	15,960,259	0.009035	3,811,986	34,441	76.03
76.97	07697	CARDIAC REHABILITATION	77,120	1,273,418	0.060561	245	15	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	306,590	15,566,726	0.019695	730,716	14,391	90.00
91.00	09100	EMERGENCY	257,074	35,331,977	0.007276	3,742,693	27,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	116,004	4,006,227	0.028956	323,328	9,362	92.00
200.00		Total (lines 50 through 199)	3,820,809	499,706,055		59,543,043	399,549	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/24/2020 11:00 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	14,222	0.00	6,294		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,555	0.00	759		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,976	0.00	2,730		40.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	9,661	0.00	6,498		44.00		
200.00	Total (lines 30 through 199)		0	0	29,414		16,281		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

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

Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,273,418	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	8,030,386	0	28,535,862	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,726,826	0	4,427,579	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,030,269	0	7,485,938	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,430,714	0	5,321,200	0	54.00
57.00	05700	CT SCAN	0.000000	4,419,961	0	9,573,352	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	955,463	0	4,151,720	0	58.00
60.00	06000	LABORATORY	0.000000	6,500,391	0	3,498,816	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	422,036	0	182,544	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,273,046	0	1,977,739	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,407,810	0	385,428	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	962,974	0	106,395	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	303,181	0	6,704	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	186,346	0	7,304	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	43,876	0	9,559	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,342,439	0	7,379,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,062,998	0	6,889,458	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,090,805	0	4,772,591	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	201,103	0	262,717	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	543,451	0	456,324	0	76.02
76.03	03140	CARDIOLOGY	0.000000	3,811,986	0	2,779,159	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	245	0	619,850	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	730,716	0	2,841,984	0	90.00
91.00	09100	EMERGENCY	0.000000	3,742,693	0	6,586,728	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	323,328	0	690,269	0	92.00
200.00		Total (lines 50 through 199)		59,543,043	0	98,948,571	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/24/2020 11:00 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.068426	28,535,862	0	0	1,952,595	50.00
51.00	05100	RECOVERY ROOM	0.130895	4,427,579	0	0	579,548	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012467	7,485,938	0	0	93,327	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045	5,321,200	0	0	974,019	54.00
57.00	05700	CT SCAN	0.030144	9,573,352	0	0	288,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979	4,151,720	0	0	294,685	58.00
60.00	06000	LABORATORY	0.126048	3,498,816	0	0	441,019	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617	182,544	0	0	59,257	63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392	1,977,739	0	0	251,948	64.00
65.00	06500	RESPIRATORY THERAPY	0.103750	385,428	0	0	39,988	65.00
66.00	06600	PHYSICAL THERAPY	0.264426	106,395	0	0	28,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323	6,704	0	0	1,973	67.00
68.00	06800	SPEECH PATHOLOGY	0.256475	7,304	0	0	1,873	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871	9,559	0	0	18,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	7,379,351	0	0	1,517,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349	6,889,458	0	0	2,558,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430	4,772,591	0	18,329	956,570	73.00
74.00	07400	RENAL DIALYSIS	0.283220	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508	262,717	0	0	14,320	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012	456,324	0	0	12,326	76.02
76.03	03140	CARDIOLOGY	0.069801	2,779,159	0	0	193,988	76.03
76.97	07697	CARDIAC REHABILITATION	0.446267	619,850	0	0	276,619	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.224183	2,841,984	0	0	637,124	90.00
91.00	09100	EMERGENCY	0.089506	6,586,728	0	0	589,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093	690,269	0	0	368,668	92.00
200.00		Subtotal (see instructions)		98,948,571	0	18,329	12,150,309	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		98,948,571	0	18,329	12,150,309	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/24/2020 11:00 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,674		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	3,674		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,674		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/24/2020 11:00 am	
					Component CCN: 14-S013			
					Title XVIII		Subprovider - IPF	PPS
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	730,944	112,772,374	0.006482	0	0	50.00
51.00	05100	RECOVERY ROOM	32,946	23,199,155	0.001420	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	159,294	32,325,681	0.004928	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,630	23,875,629	0.019879	73,843	1,468	54.00
57.00	05700	CT SCAN	244,010	37,873,310	0.006443	185,755	1,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	419,941	15,562,668	0.026984	11,954	323	58.00
60.00	06000	LABORATORY	130,613	35,765,051	0.003652	315,719	1,153	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5,629	1,396,544	0.004031	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	55,432	11,219,044	0.004941	15,673	77	64.00
65.00	06500	RESPIRATORY THERAPY	82,298	12,804,315	0.006427	497,790	3,199	65.00
66.00	06600	PHYSICAL THERAPY	86,576	8,245,881	0.010499	96,666	1,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,775	3,573,442	0.008892	15,399	137	67.00
68.00	06800	SPEECH PATHOLOGY	8,888	1,284,755	0.006918	50,075	346	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,670	236,368	0.265137	1,567	415	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,687	37,998,972	0.003702	46,776	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,659	35,594,713	0.003221	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,401	28,758,512	0.003387	146,769	497	73.00
74.00	07400	RENAL DIALYSIS	17,722	1,265,689	0.014002	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,881	1,076,774	0.001747	4,026	7	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	21,819	2,738,571	0.007967	0	0	76.02
76.03	03140	CARDIOLOGY	144,206	15,960,259	0.009035	59,921	541	76.03
76.97	07697	CARDIAC REHABILITATION	77,120	1,273,418	0.006561	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	306,590	15,566,726	0.019695	19,778	390	90.00
91.00	09100	EMERGENCY	257,074	35,331,977	0.007276	217,765	1,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,006,227	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,704,805	499,706,055		1,759,476	12,522	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
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	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,273,418	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	73,843	0	1,411	0	54.00
57.00	05700	CT SCAN		0.000000	185,755	0	6,940	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	11,954	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	315,719	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	15,673	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	497,790	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	96,666	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	15,399	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	50,075	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,567	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	46,776	0	5,890	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	146,769	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	4,026	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	59,921	0	414	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	19,778	0	1,153	0	90.00
91.00	09100	EMERGENCY		0.000000	217,765	0	1,695	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,759,476	0	18,371	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/24/2020 11:00 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.068426	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.130895	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012467	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045	1,411	0	0	258	54.00
57.00	05700	CT SCAN	0.030144	6,940	0	0	209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979	0	0	0	0	58.00
60.00	06000	LABORATORY	0.126048	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.103750	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264426	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256475	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	5,890	0	0	1,211	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349	868	0	0	322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430	0	0	3,288	0	73.00
74.00	07400	RENAL DIALYSIS	0.283220	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.069801	414	0	0	29	76.03
76.97	07697	CARDIAC REHABILITATION	0.446267	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.224183	1,153	0	0	258	90.00
91.00	09100	EMERGENCY	0.089506	1,695	0	0	152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093	0	0	0	0	92.00
200.00		Subtotal (see instructions)		18,371	0	3,288	2,439	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		18,371	0	3,288	2,439	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/24/2020 11:00 am		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	659					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	ANCILLARY	0	0					76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0					76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0					76.02
76.03	03140	CARDIOLOGY	0	0					76.03
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	659					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	659					202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
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	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,273,418	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013
Component CCN: 14-5579

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

Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 am

			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	8,340	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,697	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	145,214	0	0	0 54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	783,442	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	13,741	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,141,542	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,538,920	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,234,831	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	599,212	0	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,134	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,158	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	692,077	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	9,017	0	0	0 76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0 76.02
76.03	03140	CARDIOLOGY	0.000000	24,582	0	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	124,044	0	0	0 90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		10,327,951	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.068426	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.130895	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012467	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0.030144	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.126048	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.103750	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264426	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256475	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430	0	0	0	886	0	73.00
74.00	07400	RENAL DIALYSIS	0.283220	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.069801	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.446267	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.224183	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.089506	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	886	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	886	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:

Worksheet D

Component CCN: 14-5579

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/24/2020 11:00 am

Title XVIII

Skilled Nursing
Facility

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	178	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	178	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	178	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/24/2020 11:00 am

Title XIX			Hospital		PPS			
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	678,373	0	678,373	14,222	47.70	30.00	
31.00	INTENSIVE CARE UNIT	153,988		153,988	1,555	99.03	31.00	
40.00	SUBPROVIDER - IPF	158,126	0	158,126	3,976	39.77	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	280,787		280,787	9,661	29.06	44.00	
200.00	Total (lines 30 through 199)	1,271,274		1,271,274	29,414		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	718	34,249					30.00
31.00	INTENSIVE CARE UNIT	49	4,852					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	767	39,101					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/24/2020 11:00 am
				Title XIX	Hospital	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	730,944	112,772,374	0.006482	0	0 50.00
51.00	05100 RECOVERY ROOM	32,946	23,199,155	0.001420	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300 ANESTHESIOLOGY	159,294	32,325,681	0.004928	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	474,630	23,875,629	0.019879	0	0 54.00
57.00	05700 CT SCAN	244,010	37,873,310	0.006443	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	419,941	15,562,668	0.026984	0	0 58.00
60.00	06000 LABORATORY	130,613	35,765,051	0.003652	0	0 60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	5,629	1,396,544	0.004031	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	55,432	11,219,044	0.004941	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	82,298	12,804,315	0.006427	0	0 65.00
66.00	06600 PHYSICAL THERAPY	86,576	8,245,881	0.010499	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	31,775	3,573,442	0.008892	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	8,888	1,284,755	0.006918	0	0 68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	62,670	236,368	0.265137	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	140,687	37,998,972	0.003702	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	114,659	35,594,713	0.003221	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,401	28,758,512	0.003387	0	0 73.00
74.00	07400 RENAL DIALYSIS	17,722	1,265,689	0.014002	0	0 74.00
76.00	03950 ANCILLARY	0	0	0.000000	0	0 76.00
76.01	03560 PULMONARY FUNCTION TESTING	1,881	1,076,774	0.001747	0	0 76.01
76.02	03340 GASTRO INTESTINAL SERVICES	21,819	2,738,571	0.007967	0	0 76.02
76.03	03140 CARDIOLOGY	144,206	15,960,259	0.009035	0	0 76.03
76.97	07697 CARDIAC REHABILITATION	77,120	1,273,418	0.060561	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	306,590	15,566,726	0.019695	0	0 90.00
91.00	09100 EMERGENCY	257,074	35,331,977	0.007276	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	116,004	4,006,227	0.028956	0	0 92.00
200.00	Total (lines 50 through 199)	3,820,809	499,706,055		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/24/2020 11:00 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	14,222	0.00	718		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,555	0.00	49		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,976	0.00	0		40.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	9,661	0.00	0		44.00		
200.00	Total (lines 30 through 199)		0	0	29,414		767		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

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

Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,273,418	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

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

Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:00 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	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/24/2020 11:00 am	
					Component CCN: 14-S013			
					Title XIX		Subprovider - IPF	PPS
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	730,944	112,772,374	0.006482	0	0	50.00
51.00	05100	RECOVERY ROOM	32,946	23,199,155	0.001420	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	159,294	32,325,681	0.004928	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,630	23,875,629	0.019879	0	0	54.00
57.00	05700	CT SCAN	244,010	37,873,310	0.006443	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	419,941	15,562,668	0.026984	0	0	58.00
60.00	06000	LABORATORY	130,613	35,765,051	0.003652	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5,629	1,396,544	0.004031	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	55,432	11,219,044	0.004941	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	82,298	12,804,315	0.006427	0	0	65.00
66.00	06600	PHYSICAL THERAPY	86,576	8,245,881	0.010499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,775	3,573,442	0.008892	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,888	1,284,755	0.006918	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,670	236,368	0.265137	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,687	37,998,972	0.003702	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,659	35,594,713	0.003221	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,401	28,758,512	0.003387	0	0	73.00
74.00	07400	RENAL DIALYSIS	17,722	1,265,689	0.014002	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,881	1,076,774	0.001747	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	21,819	2,738,571	0.007967	0	0	76.02
76.03	03140	CARDIOLOGY	144,206	15,960,259	0.009035	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	77,120	1,273,418	0.006561	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	306,590	15,566,726	0.019695	0	0	90.00
91.00	09100	EMERGENCY	257,074	35,331,977	0.007276	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,006,227	0.000000		0	92.00
200.00		Total (lines 50 through 199)	3,704,805	499,706,055		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
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	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,273,418	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
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	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	112,772,374	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	23,199,155	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	32,325,681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,875,629	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	37,873,310	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	15,562,668	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	35,765,051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,396,544	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	11,219,044	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,804,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,245,881	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,573,442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,284,755	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	236,368	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	37,998,972	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	35,594,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	28,758,512	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,265,689	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	1,076,774	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	2,738,571	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	15,960,259	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,273,418	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	15,566,726	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	35,331,977	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	4,006,227	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	499,706,055		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,222	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,222	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)		11,790	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) (see instructions)		6,294	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)		12,512,612	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)		12,512,612	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)		12,512,612	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)		879.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,537,524	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,537,524	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,509,446	1,555	1,613.79	759	1,224,867	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)					8,832,525	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,594,916	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)					375,388	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					399,549	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					774,937	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,819,979	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,432	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					879.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,139,698	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	678,373	12,512,612	0.054215	2,139,698	116,004	90.00		
91.00	Nursing School cost	0	12,512,612	0.000000	2,139,698	0	91.00		
92.00	Allied health cost	0	12,512,612	0.000000	2,139,698	0	92.00		
93.00	All other Medical Education	0	12,512,612	0.000000	2,139,698	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,976	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,976	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)		3,976	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) (see instructions)		2,730	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)		3,627,461	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)		3,627,461	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)		3,627,461	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)		912.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,490,688	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)		2,490,688	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					226,700
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,717,388
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					108,572
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,522
52.00 Total Program excludable cost (sum of lines 50 and 51)					121,094
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,596,294
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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	158,126	3,627,461	0.043591	0	0	90.00
91.00	Nursing School cost	0	3,627,461	0.000000	0	0	91.00
92.00	Allied health cost	0	3,627,461	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,627,461	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,661	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)		9,661	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) (see instructions)		6,498	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)		4,004,799	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)		4,004,799	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)		4,004,799	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					4,004,799	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					414.53	71.00
72.00	Program routine service cost (line 9 x line 71)					2,693,616	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					2,693,616	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					2,693,616	83.00
84.00	Program inpatient ancillary services (see instructions)					2,275,930	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					4,969,546	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: 14-0013
Component CCN: 14-5579

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

Worksheet D-1
Date/Time Prepared:
8/24/2020 11:00 am

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XIX	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)		14,222	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,222	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)		11,790	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) (see instructions)		718	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)		12,512,612	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)		12,512,612	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)		12,512,612	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)		879.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		631,704	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)		631,704	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
8/24/2020 11:00 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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,509,446	1,555	1,613.79	49	79,076
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)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					710,780
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					39,101
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					39,101
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					671,679
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,432
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					879.81
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,139,698

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
8/24/2020 11:00 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	678,373	12,512,612	0.054215	2,139,698	116,004
91.00	Nursing School cost	0	12,512,612	0.000000	2,139,698	0
92.00	Allied health cost	0	12,512,612	0.000000	2,139,698	0
93.00	All other Medical Education	0	12,512,612	0.000000	2,139,698	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,976	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,976	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)		3,976	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) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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)		3,627,461	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)		3,627,461	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)		3,627,461	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)		912.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	158,126	3,627,461	0.043591	0	0	90.00
91.00	Nursing School cost	0	3,627,461	0.000000	0	0	91.00
92.00	Allied health cost	0	3,627,461	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,627,461	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am
		Title XIX	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,661	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)		9,661	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) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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)		4,004,799	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)		4,004,799	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)		4,004,799	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:00 am	
				Title XIX		Skilled Nursing Facility	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
		Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						4,004,799 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						414.53 71.00
72.00	Program routine service cost (line 9 x line 71)						0 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						0 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						280,787 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						29.06 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						0 83.00
84.00	Program inpatient ancillary services (see instructions)						0 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						0 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: 14-0013
 Component CCN: 14-5579

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

 Worksheet D-1
 Date/Time Prepared:
 8/24/2020 11:00 am

Title XIX

 Skilled Nursing
 Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/24/2020 11:00 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		17,590,376	30.00
31.00	03100	INTENSIVE CARE UNIT		3,956,860	31.00
40.00	04000	SUBPROVIDER - IPF		54,694	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.068426	8,030,386	50.00
51.00	05100	RECOVERY ROOM	0.130895	1,726,826	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012467	2,030,269	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183045	2,430,714	54.00
57.00	05700	CT SCAN	0.030144	4,419,961	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070979	955,463	58.00
60.00	06000	LABORATORY	0.126048	6,500,391	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.324617	422,036	63.00
64.00	06400	INTRAVENOUS THERAPY	0.127392	1,273,046	64.00
65.00	06500	RESPIRATORY THERAPY	0.103750	4,407,810	65.00
66.00	06600	PHYSICAL THERAPY	0.264426	962,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294323	303,181	67.00
68.00	06800	SPEECH PATHOLOGY	0.256475	186,346	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.905871	43,876	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	5,342,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371349	6,062,998	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200430	5,090,805	73.00
74.00	07400	RENAL DIALYSIS	0.283220	0	74.00
76.00	03950	ANCILLARY	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.054508	201,103	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.027012	543,451	76.02
76.03	03140	CARDIOLOGY	0.069992	3,811,986	76.03
76.97	07697	CARDIAC REHABILITATION	0.446267	245	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.224183	730,716	90.00
91.00	09100	EMERGENCY	0.089506	3,742,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.534093	323,328	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		59,543,043	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		59,543,043	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/24/2020 11:00 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		6,481,644		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.068426	0	0	50.00
51.00	05100 RECOVERY ROOM	0.130895	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.012467	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.183045	73,843	13,517	54.00
57.00	05700 CT SCAN	0.030144	185,755	5,599	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.070979	11,954	848	58.00
60.00	06000 LABORATORY	0.126048	315,719	39,796	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.324617	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.127392	15,673	1,997	64.00
65.00	06500 RESPIRATORY THERAPY	0.103750	497,790	51,646	65.00
66.00	06600 PHYSICAL THERAPY	0.264426	96,666	25,561	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.294323	15,399	4,532	67.00
68.00	06800 SPEECH PATHOLOGY	0.256475	50,075	12,843	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.905871	1,567	2,986	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	46,776	9,620	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371349	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.200430	146,769	29,417	73.00
74.00	07400 RENAL DIALYSIS	0.283220	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.054508	4,026	219	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.027012	0	0	76.02
76.03	03140 CARDIOLOGY	0.069992	59,921	4,194	76.03
76.97	07697 CARDIAC REHABILITATION	0.446267	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.224183	19,778	4,434	90.00
91.00	09100 EMERGENCY	0.089506	217,765	19,491	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.534093	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,759,476	226,700	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,759,476		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/24/2020 11:00 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.068426	0	0	50.00
51.00	05100 RECOVERY ROOM	0.130895	8,340	1,092	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.012467	5,697	71	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.183045	145,214	26,581	54.00
57.00	05700 CT SCAN	0.030144	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.070979	0	0	58.00
60.00	06000 LABORATORY	0.126048	783,442	98,751	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.324617	13,741	4,461	63.00
64.00	06400 INTRAVENOUS THERAPY	0.127392	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.103750	2,141,542	222,185	65.00
66.00	06600 PHYSICAL THERAPY	0.264426	3,538,920	935,782	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.294323	2,234,831	657,762	67.00
68.00	06800 SPEECH PATHOLOGY	0.256475	599,212	153,683	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.905871	3,134	5,973	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.205653	4,158	855	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371349	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.200430	692,077	138,713	73.00
74.00	07400 RENAL DIALYSIS	0.283220	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.054508	9,017	491	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.027012	0	0	76.02
76.03	03140 CARDIOLOGY	0.069992	24,582	1,721	76.03
76.97	07697 CARDIAC REHABILITATION	0.446267	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.224183	124,044	27,809	90.00
91.00	09100 EMERGENCY	0.089506	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.534093	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,327,951	2,275,930	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)		10,327,951		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,893,166	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,847,835	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		48,962	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		8,601	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		103.34	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		5.68	31.00
32.00	Sum of lines 30 and 31		5.68	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	12,798,564		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		12,798,564	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,037,162	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,835,726	59.00
60.00	Primary payer payments		408	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,835,318	61.00
62.00	Deductibles billed to program beneficiaries		1,640,532	62.00
63.00	Coinurance billed to program beneficiaries		14,531	63.00
64.00	Allowable bad debts (see instructions)		174,084	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		113,155	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,890	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,293,410	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		11,371	70.93
70.94	HRR adjustment amount (see instructions)		-342,120	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,962,661	71.00
71.01	Sequestration adjustment (see instructions)		239,253	71.01
71.02	Demonstration payment adjustment amount after sequestration		126,057	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		11,632,065	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-34,714	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/24/2020 11:00 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,893,166	0	9,893,166		9,893,166
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,847,835	0		2,847,835	2,847,835
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	48,962	0	48,962		48,962
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,601	0		8,601	8,601
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	
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	12,798,564	0	9,942,128	2,856,436	12,798,564
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	12,798,564	0	9,942,128	2,856,436	12,798,564
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,037,162	0	809,738	227,424	1,037,162

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/24/2020 11:00 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,751,866	3,083,860	13,835,726
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,023,122	0	798,744	224,378	1,023,122
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	2,172	0	1,729	443	2,172
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0116	0.0116	0.0116	0.0116	
25.00	Disproportionate share adjustment (see instructions)	11.00	11,868	0	9,265	2,603	11,868
26.00	Total prospective capital payments (see instructions)	12.00	1,037,162	0	809,738	227,424	1,037,162
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/24/2020 11:00 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,893,166	9,893,166		9,893,166	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,847,835		2,847,835	2,847,835	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	48,962	48,962		48,962	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,601		8,601	8,601	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	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	12,798,564	9,942,128	2,856,436	12,798,564	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	12,798,564	9,942,128	2,856,436	12,798,564	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,037,162	809,738	227,424	1,037,162	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,751,866	3,083,860	13,835,726	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/24/2020 11:00 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,023,122	798,744	224,378	1,023,122	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	2,172	1,729	443	2,172	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	0.0116	0.0116	0.0116		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	11,868	9,265	2,603	11,868	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,037,162	809,738	227,424	1,037,162	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	11,371	25,137	-13,766	11,371	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	-342,120	-290,859	-51,261	-342,120	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: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,674	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,150,309	2.00
3.00	OPPS payments		10,940,427	3.00
4.00	Outlier payment (see instructions)		11,736	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)		3,674	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		18,329	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)		18,329	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		18,329	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		14,655	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)		3,674	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		10,952,163	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,153,489	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,802,348	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,802,348	30.00
31.00	Primary payer payments		539	31.00
32.00	Subtotal (line 30 minus line 31)		8,801,809	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)		227,430	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		147,830	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		186,721	36.00
37.00	Subtotal (see instructions)		8,949,639	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-105	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		945	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,949,744	40.00
40.01	Sequestration adjustment (see instructions)		178,995	40.01
40.02	Demonstration payment adjustment amount after sequestration		94,042	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		8,689,426	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-12,719	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		PROCTOR HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/24/2020 11:00 am	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		659	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,439	2.00	
3.00	OPPS payments		1,736	3.00	
4.00	Outlier payment (see instructions)		0	4.00	
4.01	Outlier reconciliation amount (see instructions)		0	4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00	
6.00	Line 2 times line 5		0	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00	
8.00	Transitional corridor payment (see instructions)		0	8.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		659	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		3,288	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)		3,288	14.00	
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00	
18.00	Total customary charges (see instructions)		3,288	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,629	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)		659	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)		1,736	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		226	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,169	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		2,169	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		2,169	32.00	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00	
34.00	Allowable bad debts (see instructions)		0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00	
37.00	Subtotal (see instructions)		2,169	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99	
40.00	Subtotal (see instructions)		2,169	40.00	
40.01	Sequestration adjustment (see instructions)		43	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		2,051	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		75	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		178	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		178	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		886	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		886	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)		886	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		708	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)		178	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		178	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		178	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		178	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		178	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		178	40.00
40.01	Sequestration adjustment (see instructions)		4	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		200	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-26	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/24/2020 11:00 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		11,632,065		8,689,426	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)		11,632,065		8,689,426	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		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		34,714		12,719	6.02	
7.00	Total Medicare program liability (see instructions)		11,597,351		8,676,707	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 8/24/2020 11:00 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,179,481		2,051	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,179,481		2,051	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		11		75	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,179,492		2,126	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0013
 Component CCN: 14-5579

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/24/2020 11:00 am

Title XVIII

 Skilled Nursing
 Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,157,089		200	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)		3,157,089		200	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		26	6.02
7.00	Total Medicare program liability (see instructions)		3,157,088		174	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: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,425,839	1.00
2.00	Net IPF PPS Outlier Payments		11,065	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		10.893151	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,436,904	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,436,904	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,436,904	18.00
19.00	Deductibles		122,568	19.00
20.00	Subtotal (line 18 minus line 19)		2,314,336	20.00
21.00	Coinurance		90,365	21.00
22.00	Subtotal (line 20 minus line 21)		2,223,971	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,223,971	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,223,971	31.00
31.01	Sequestration adjustment (see instructions)		44,479	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		2,179,481	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		11	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		11,065	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			3,480,854
2.00	Routine service other pass through costs			0
3.00	Ancillary service other pass through costs			0
4.00	Subtotal (sum of lines 1 through 3)			3,480,854
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0
7.00	Coinsurance			200,975
8.00	Allowable bad debts (see instructions)			0
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
10.00	Adjusted reimbursable bad debts (see instructions)			0
11.00	Utilization review			0
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			3,279,879
13.00	Inpatient primary payer payments			1,449
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
14.99	Demonstration payment adjustment amount before sequestration			0
15.00	Subtotal (see instructions)			3,278,430
15.01	Sequestration adjustment (see instructions)			65,569
15.02	Demonstration payment adjustment amount after sequestration			55,773
16.00	Interim payments			3,157,089
17.00	Tentative settlement (for contractor use only)			0
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			-1
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0

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

Provider CCN: 14-0013

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

Worksheet G

Date/Time Prepared:
8/24/2020 11:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	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	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	0	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	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)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0013

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

Worksheet G-1

Date/Time Prepared:
8/24/2020 11:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-77,560,098				2.00
3.00	Total (sum of line 1 and line 2)		-77,560,098		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-77,560,098		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)		-77,560,098		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/24/2020 11:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	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)	0		0	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		77,560,098		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)		77,560,098		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0013

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

Worksheet G-3

Date/Time Prepared:
8/24/2020 11:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	77,560,098	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-77,560,098	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-77,560,098	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)	-77,560,098	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0013

Period:

Worksheet I-1

Component CCN: 14-2337

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

8/24/2020 11:00 am

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	96,310	HOURS OF SERVICE	2,446.00	1.18
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00
3.00	NURSES AIDES	273	HOURS OF SERVICE	7.00	0.00
4.00	TECHNICIANS	3,753	HOURS OF SERVICE	250.00	0.12
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	0	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	50,074	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	150,410			9.00
10.00	EMPLOYEE BENEFITS	28,113	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	53,145	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	5,231	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	60,642	REQUISITIONS		14.00
15.00	DRUGS	4,029	REQUISITIONS		15.00
16.00	OTHER	40,715	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	342,285			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	6,230	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	317	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	0	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	61,252	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	78,250	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	10,865	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	499,199			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	ANCILLARY	0	CHARGES	0	30.00
30.01	PULMONARY FUNCTION TESTING	0	CHARGES	0	30.01
30.02	GASTRO INTESTINAL SERVICES	0	CHARGES	0	30.02
30.03	CARDIOLOGY	0	CHARGES	0	30.03
30.97	CARDIAC REHABILITATION	0	CHARGES	0	30.97
31.00	TOTAL COSTS (SUM OF LINES 27-30)	499,199			31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0013

Period:

Worksheet I-2

Component CCN: 14-2337

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/24/2020 11:00 am

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	137,625	5,548	96,310	4,026	28,113	4,029	1.00
MAINTENANCE								
2.00	Hemodialysis	13,763	555	9,631	403	2,811	403	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	123,862	4,993	86,679	3,623	25,302	3,626	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	137,625	5,548	96,310	4,026	28,113	4,029	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	60,642	0	336,293	162,906	499,199		1.00
MAINTENANCE								
2.00	Hemodialysis	6,064	0	33,630	16,291	49,921		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	54,578	0	302,663	146,615	449,278		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	60,642	0	336,293	162,906	499,199		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					499,199		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013
Component CCN: 14-2337Period:
From 01/01/2019
To 12/31/2019Worksheet I-3
Date/Time Prepared:
8/24/2020 11:00 am

						Renal Dialysis		8/24/2020 11:00 am	
			Capital Related Costs		Direct Patient Care Salary				
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)		
		0	1.00	2.00	3.00	4.00	5.00		
1.00	Total Renal Department Costs		137,625	5,548	96,310	4,026	28,113	1.00	
MAINTENANCE									
2.00	Hemodialysis		10	10.00	10.00	10.00	10	2.00	
2.01	AKI-Hemodialysis		0	0.00	0.00	0.00	0	2.01	
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00	
3.01	AKI-Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.01	
TRAINING									
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00	
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00	
6.00	CAPD		0	0.00	0.00	0.00	0	6.00	
7.00	CCPD		0	0.00	0.00	0.00	0	7.00	
HOME									
8.00	Hemodialysis		90	90.00	90.00	90.00	90	8.00	
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00	
10.00	CAPD		0	0.00	0.00	0.00	0	10.00	
11.00	CCPD		0	0.00	0.00	0.00	0	11.00	
OTHER BILLABLE SERVICES									
12.00	Inpatient Dialysis Treatments	0	0	0.00	0.00	0.00	0	12.00	
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00	
14.00	ESAs							14.00	
15.00								15.00	
16.00	Other		0	0.00	0.00	0.00	0	16.00	
17.00	Total Statistical Basis		100	100.00	100.00	100.00	100	17.00	
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		1,376.250000	55.480000	963.100000	40.260000	281.130000	18.00	
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)			
		6.00	7.00	8.00	9.00	10.00			
1.00	Total Renal Department Costs	4,029	60,642	0	336,293	162,906		1.00	
MAINTENANCE									
2.00	Hemodialysis	10	10	0				2.00	
2.01	AKI-Hemodialysis	0	0	0				2.01	
3.00	Intermittent Peritoneal	0	0	0				3.00	
3.01	AKI-Intermittent Peritoneal	0	0	0				3.01	
TRAINING									
4.00	Hemodialysis	0	0	0				4.00	
5.00	Intermittent Peritoneal	0	0	0				5.00	
6.00	CAPD	0	0	0				6.00	
7.00	CCPD	0	0	0				7.00	
HOME									
8.00	Hemodialysis	90	90	0				8.00	
9.00	Intermittent Peritoneal	0	0	0				9.00	
10.00	CAPD	0	0	0				10.00	
11.00	CCPD	0	0	0				11.00	
OTHER BILLABLE SERVICES									
12.00	Inpatient Dialysis Treatments	0	0	0				12.00	
13.00	Method II Home Patient	0	0	0				13.00	
14.00	ESAs							14.00	
15.00								15.00	
16.00	Other	0	0	0				16.00	
17.00	Total Statistical Basis	100	100	0		336,293		17.00	
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	40.290000	606.420000	0.000000		0.484417		18.00	

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0013
Component CCN: 14-2337Period:
From 01/01/2019
To 12/31/2019Worksheet I-4
Date/Time Prepared:
8/24/2020 11:00 am

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	32	49,921	1,560.03	25	39,001
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	317	449,278	1,417.28	249	352,903
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	0	0	0.00	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	349	499,199		274	391,904
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	349				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	6,541	261.64			
2.00	Maintenance - Peritoneal Dialysis	0	0.00			
3.00	Training - Hemodialysis	0	0.00			
4.00	Training - Peritoneal Dialysis	0	0.00			
5.00	Training - CAPD	0	0.00			
6.00	Training - CCPD	0	0.00			
7.00	Home Program - Hemodialysis	71,046	285.33			
8.00	Home Program - Peritoneal Dialysis	0	0.00			
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			
10.00	Home Program - CCPD	0	0.00			
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	77,587				
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet I-5 Date/Time Prepared: 8/24/2020 11:00 am
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	391,904		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	77,587	77,587	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	77,587	77,587	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	15,517	15,517	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	15,517	15,517	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	15,517	8.00
9.00	Program payment (see instructions)	0	62,070	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	499,199		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	499,199		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0013	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/24/2020 11:00 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,023,122	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,172	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		36.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		5.68	8.00
9.00	Sum of lines 7 and 8		5.68	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.16	10.00
11.00	Disproportionate share adjustment (see instructions)		11,868	11.00
12.00	Total prospective capital payments (see instructions)		1,037,162	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00