

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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S
Parts I-III
Date/Time Prepared:
2/27/2020 10:31 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2020	Time: 10:31 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) TIMOTHY MOORE

Officer or Administrator of Provider(s)

VP-FINANCE, CAO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	829,956	383,094	0	0	1.00
2.00	Subprovider - IPF	0	191,417	51		0	2.00
3.00	Subprovider - IRF	0	65,426	-17		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	35,970	-22,087		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		23,940		0	10.00
200.00	Total	0	1,122,769	384,981	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: 14-0015		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 10:31 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1005 BROADWAY			PO Box:				1.00		
2.00	City: QUINCY			State: IL		Zip Code: 62301		County:		
		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		BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		BLESSING PSYCHIATRIC UNIT	14S015	99914	4	10/01/1993	N	P	O
5.00	Subprovider - IRF		BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984			
15.00	Hospital-Based Health Clinic - RHC		GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018		09/30/2019	
21.00	Type of Control (see instructions)						2			
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N	
23.00	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.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,524	710	0	1,219	4,799	138	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

		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.	95	24	0	67	122		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.					2		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.					2		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.					1		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.					10/01/2018	09/30/2019	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						20.00	1
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.01	1
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.02	1

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.03	1		60.04	
60.05	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.04	1		60.05	
60.06	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.05	1		60.06	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00		61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00		61.20
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N		63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		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	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			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.	Y			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)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0015		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 10:31 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	2.00
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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y					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.	1					118.00
		Premiums	Losses		Insurance		
		1.00	2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	122,813	2,230,552		0		
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0015		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 10:31 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BLESSING CROPORATE SERVICES		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00		
142.00	Street: BROADWAY AT 11TH STREET		PO Box:				142.00		
143.00	City: QUINCY		State: IL		Zip Code: 62301		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 10:31 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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	12/31/2019	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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 10:31 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		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.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		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.	CONNIE	ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT COORDINATOR	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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	223	81,395	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)		223	81,395	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,125	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)		248	90,520	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	41	14,965		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		327				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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	22,778	1,296	39,656			1.00
2.00	HMO and other (see instructions)	4,383	6,728				2.00
3.00	HMO IPF Subprovider	109	4,201				3.00
4.00	HMO IRF Subprovider	269	213				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)	22,778	1,296	39,656			7.00
8.00	INTENSIVE CARE UNIT	2,359	150	4,634			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		78	2,293			13.00
14.00	Total (see instructions)	25,137	1,524	46,583	16.92	2,100.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,492	2,839	11,621	0.39	82.23	16.00
17.00	SUBPROVIDER - IRF	2,767	95	4,307	0.27	25.22	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,091	0	5,857	0.00	30.70	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	25,637	0	42,544	0.00	45.52	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	18.40	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,677	0	2,774	0.00	7.61	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)				17.58	2,310.56	27.00
28.00	Observation Bed Days		0	6,256			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			743			30.00
31.00	Employee discount days - IRF			115			31.00
32.00	Labor & delivery days (see instructions)	0	138	267			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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,947	516	11,606	1.00
2.00 HMO and other (see instructions)			959	1,239		2.00
3.00 HMO IPF Subprovider				793		3.00
4.00 HMO IRF Subprovider				10		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	5,947	516	11,606	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	205	409	2,007	16.00
17.00 SUBPROVIDER - IRF	0.00	0	189	10	291	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	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 10:31 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	139,493,088	0	139,493,088	4,794,077.82	29.10
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		247,812	0	247,812	1,530.00	161.97
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		13,579,328	0	13,579,328	103,609.12	131.06
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		411,535	0	411,535	15,376.00	26.76
7.00	Interns & residents (in an approved program)	21.00	1,116,867	0	1,116,867	39,217.24	28.48
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	1,586,410	-23,701	1,562,709	63,050.33	24.79
10.00	Excluded area salaries (see instructions)		16,523,695	829,836	17,353,531	527,359.00	32.91
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,358,055	0	2,358,055	30,904.00	76.30
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		509,135	0	509,135	3,550.00	143.42
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		6,237,418	0	6,237,418	68,535.13	91.01
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		40,190,327	0	40,190,327		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		6,369,612	0	6,369,612		
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		44,636	0	44,636		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		2,566,455	0	2,566,455		
24.00	Wage-related costs (RHC/FQHC)		154,401	0	154,401		
25.00	Interns & residents (in an approved program)		403,320	0	403,320		
25.50	Home office wage-related (core)		1,259,741	0	1,259,741		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,000,065	0	3,000,065	189,219.53	15.85
27.00	Administrative & General	5.00	23,764,243	-12,219	23,752,024	827,466.86	28.70

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/27/2020 10:31 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,145,526	0	1,145,526	5,082.11	225.40	28.00
29.00	Maintenance & Repairs	6.00	2,857,049	0	2,857,049	123,784.17	23.08	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	41,662	0	41,662	2,908.95	14.32	31.00
32.00	Housekeeping	9.00	2,632,018	0	2,632,018	184,171.17	14.29	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,571,781	-1,679,630	892,151	70,655.71	12.63	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,679,630	1,679,630	114,285.69	14.70	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	8,664,575	-83,159	8,581,416	271,985.53	31.55	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,736,036	0	3,736,036	179,348.62	20.83	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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/27/2020 10:31 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	125,530,884	0	125,530,884	4,640,957.57	27.05	1.00
2.00	Excluded area salaries (see instructions)	18,110,105	806,135	18,916,240	590,409.33	32.04	2.00
3.00	Subtotal salaries (line 1 minus line 2)	107,420,779	-806,135	106,614,644	4,050,548.24	26.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,104,608	0	9,104,608	102,989.13	88.40	4.00
5.00	Subtotal wage-related costs (see inst.)	41,494,704	0	41,494,704	0.00	38.92	5.00
6.00	Total (sum of lines 3 thru 5)	158,020,091	-806,135	157,213,956	4,153,537.37	37.85	6.00
7.00	Total overhead cost (see instructions)	48,412,955	-95,378	48,317,577	1,968,908.34	24.54	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2020 10:31 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		5,419,155	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)		4,652,522	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)		27,212,591	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		99,483	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)		320,910	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,559,386	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		9,110,439	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		95,908	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		1,258,357	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		49,728,751	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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,740,595	49,728,751	1.00
2.00	Hospital	2,358,055	40,190,327	2.00
3.00	Subprovider - IPF	67,913	1,434,439	3.00
4.00	Subprovider - IRF	215,450	516,949	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	99,177	526,207	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,040,871	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	403,871	13.00
14.00	Hospital-Based Health Clinic RHC	0	154,401	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	5,461,686	18.00

Health Financial Systems		BLESSING HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0015 Component CCN: 14-7031	Period: From 10/01/2018 To 09/30/2019	Worksheet S-4 Date/Time Prepared: 2/27/2020 10:31 pm	
					Home Health Agency I	PPS	
				1.00			
0.00	County				ADAMS	0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	8,884	0	3,954	12,838	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	902.00	0.00	289.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00			1.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	4.00
5.00	Other Administrative Personnel				8.32	0.00	5.00
6.00	Direct Nursing Service				14.48	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	7.00
8.00	Physical Therapy Service				11.46	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	9.00
10.00	Occupational Therapy Service				2.71	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00
12.00	Speech Pathology Service				0.38	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	13.00
14.00	Medical Social Service				1.00	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	15.00
16.00	Home Health Aide				6.17	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				3		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914					20.00
20.01		99926					20.01
20.02		17860					20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	11,540	556	238	143	12,477	21.00
22.00	Skilled Nursing Visit Charges	1,873,064	90,152	38,716	23,174	2,025,106	22.00
23.00	Physical Therapy Visits	7,278	128	88	76	7,570	23.00
24.00	Physical Therapy Visit Charges	1,180,396	20,776	14,304	12,312	1,227,788	24.00
25.00	Occupational Therapy Visits	1,869	90	13	19	1,991	25.00
26.00	Occupational Therapy Visit Charges	303,018	14,580	2,122	3,078	322,798	26.00
27.00	Speech Pathology Visits	183	0	0	15	198	27.00
28.00	Speech Pathology Visit Charges	29,686	0	0	2,430	32,116	28.00
29.00	Medical Social Service Visits	27	1	0	0	28	29.00
30.00	Medical Social Service Visit Charges	4,374	162	0	0	4,536	30.00
31.00	Home Health Aide Visits	2,742	614	3	14	3,373	31.00
32.00	Home Health Aide Visit Charges	245,640	55,292	270	1,260	302,462	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	23,639	1,389	342	267	25,637	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,636,178	180,962	55,412	42,254	3,914,806	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,336		126	23	1,485	36.00
37.00	Total Number of Outlier Episodes		24		0	24	37.00
38.00	Total Non-Routine Medical Supply Charges	506,084	726,845	6,574	6,345	1,245,848	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 10:31 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	30	0	30 7.00
8.00		RHL	68	0	68 8.00
9.00		RMX	19	0	19 9.00
10.00		RML	28	0	28 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	38	0	38 15.00
16.00		RVB	24	0	24 16.00
17.00		RVA	6	0	6 17.00
18.00		RHC	915	0	915 18.00
19.00		RHB	1,152	0	1,152 19.00
20.00		RHA	958	0	958 20.00
21.00		RMC	165	0	165 21.00
22.00		RMB	182	0	182 22.00
23.00		RMA	110	0	110 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	3	0	3 27.00
28.00		ES1	15	0	15 28.00
29.00		HE2	13	0	13 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	44	0	44 32.00
33.00		HC2	7	0	7 33.00
34.00		HC1	38	0	38 34.00
35.00		HB2	9	0	9 35.00
36.00		HB1	83	0	83 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	19	0	19 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	24	0	24 40.00
41.00		LC2	9	0	9 41.00
42.00		LC1	9	0	9 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	22	0	22 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	23	0	23 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	21	0	21 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	5	0	5 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	51	0	51 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 10:31 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,091	0	4,091	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		1,586,410	25.26	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		6,280,808			207.00

Health Financial Systems			BLESSING HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0015 Component CCN: 14-3422		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 10:31 pm	
			RHC I		Cost	
			1.00			
Clinic Address and Identification						
1.00	Street		102 PRAIRIE MILLS ROAD		1.00	
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County		GOLDEN IL 62339		2.00	
			1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00	
			Grant Award		Date	
			1.00		2.00	
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	Appalachian Regional Commission				7.00	
8.00	Look-Alikes				8.00	
9.00	OTHER (SPECIFY)				9.00	
			1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00	
			Sunday		Monday	
			from to		from to	
			1.00 2.00		3.00 4.00	
			Tuesday		from	
			1.00		5.00	
11.00	Facility hours of operations (1)					
11.00	CLINIC		08:00 17:00		08:00 11.00	
			1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00	
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00	
			Y/N V		XVIII XIX	
			1.00 2.00		3.00 4.00	
					Total Visits	
					5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00	
			County			
			4.00			
2.00	City, State, ZIP Code, County		ADAMS		2.00	
			Tuesday		Wednesday	
			to from to		from to	
			6.00 7.00 8.00		9.00 10.00	
			Thursday			
11.00	Facility hours of operations (1)					
11.00	CLINIC		17:00 08:00 17:00 08:00 17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0015 Component CCN: 14-3422		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/27/2020 10:31 pm	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)								
	CLINIC	08:00	17:00						11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015

Period:

Worksheet S-9

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019PARTS I THROUGH IV
Date/Time Prepared:
2/27/2020 10:31 pm

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	12,042	286	852	13,180	11.00
12.00	Hospice Inpatient Respite Care	23	0	0	23	12.00
13.00	Hospice General Inpatient Care	370	69	64	503	13.00
14.00	Total Hospice Days	12,435	355	916	13,706	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	23	0	0	23	15.00
16.00	Hospice General Inpatient Care	370	69	64	503	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/27/2020 10:31 pm	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.196347	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			13,005,383	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			19,132,478	5.00
6.00	Medicaid charges			245,840,984	6.00
7.00	Medicaid cost (line 1 times line 6)			48,270,140	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)			16,132,279	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)			16,132,279	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)	22,079,885	14,799,550	36,879,435	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,335,319	14,799,550	19,134,869	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)	4,335,319	14,799,550	19,134,869	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)			21,207,212	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,829,872	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,815,190	27.01
28.00	Non-Medicare bad debt expense (see instructions)			18,392,022	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			4,596,536	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			23,731,405	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			39,863,684	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		656	656	30,220	30,876	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		5,200,594	5,200,594	-356	5,200,238	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1,714,651	1,714,651	2,040,807	3,755,458	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I		0	0	66,156	66,156	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL		0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST		0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,430,340	11,430,340	34,201	11,464,541	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,000,065	46,043,231	49,043,296	0	49,043,296	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,764,243	104,591,080	128,355,323	-149,737	128,205,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,857,049	6,271,456	9,128,505	0	9,128,505	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,662	1,445,335	1,486,997	0	1,486,997	8.00
9.00	00900	HOUSEKEEPING	2,632,018	1,717,805	4,349,823	79,178	4,429,001	9.00
10.00	01000	DIETARY	2,571,781	4,258,668	6,830,449	-4,460,966	2,369,483	10.00
11.00	01100	CAFETERIA	0	0	0	4,460,966	4,460,966	11.00
13.00	01300	NURSING ADMINISTRATION	8,664,575	953,329	9,617,904	-83,238	9,534,666	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,736,036	1,018,580	4,754,616	0	4,754,616	16.00
20.00	02000	NURSING SCHOOL	3,834,519	3,042,689	6,877,208	525,020	7,402,228	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,116,867	0	1,116,867	0	1,116,867	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,098,688	2,098,688	0	2,098,688	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	293,423	17,607	311,030	0	311,030	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	72,304	5,387	77,691	0	77,691	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	331,890	13,958	345,848	0	345,848	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	167,185	167,185	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	155,122	155,122	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,402,920	3,572,824	24,975,744	-432,881	24,542,863	30.00
31.00	03100	INTENSIVE CARE UNIT	3,883,553	1,630,415	5,513,968	-208,881	5,305,087	31.00
40.00	04000	SUBPROVIDER - IPF	4,290,478	195,917	4,486,395	-31,840	4,454,555	40.00
41.00	04100	SUBPROVIDER - IRF	1,556,538	351,230	1,907,768	-21,927	1,885,841	41.00
43.00	04300	NURSERY	309,553	55,189	364,742	-25,080	339,662	43.00
44.00	04400	SKILLED NURSING FACILITY	1,586,410	226,554	1,812,964	-24,490	1,788,474	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,500,979	21,005,461	31,506,440	-15,290,554	16,215,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	669,169	278,102	947,271	-155,823	791,448	52.00
53.00	05300	ANESTHESIOLOGY	226,051	677,962	904,013	-338,708	565,305	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,639,575	1,944,401	6,583,976	-295,707	6,288,269	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,175,485	271,728	1,447,213	-11,209	1,436,004	55.00
57.00	05700	CT SCAN	571,596	421,465	993,061	-35,623	957,438	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	328,746	404,462	733,208	-336	732,872	58.00
60.00	06000	LABORATORY	3,399,999	4,141,263	7,541,262	-123,074	7,418,188	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	146,573	1,303,105	1,449,678	0	1,449,678	62.00
65.00	06500	RESPIRATORY THERAPY	2,116,442	579,306	2,695,748	-301,734	2,394,014	65.00
66.00	06600	PHYSICAL THERAPY	1,433,984	27,672	1,461,656	-1,846	1,459,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	854,030	8,623	862,653	-414	862,239	67.00
68.00	06800	SPEECH PATHOLOGY	255,786	7,381	263,167	-1,778	261,389	68.00
69.00	06900	ELECTROCARDIOLOGY	2,120,411	8,573,933	10,694,344	-7,833,336	2,861,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	457,176	106,690	563,866	26,452	590,318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	894,867	1,014,485	1,909,352	10,276,228	12,185,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,291,803	14,291,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,341,221	19,036,753	23,377,974	-538	23,377,436	73.00
74.00	07400	RENAL DIALYSIS	0	845,580	845,580	0	845,580	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	454,477	425,509	879,986	4,465	884,451	88.00
90.00	09000	CLINIC	448,395	84,784	533,179	-221	532,958	90.00
90.01	09001	OUTPATIENT INFUSION	456,035	78,499	534,534	-1,879	532,655	90.01
91.00	09100	EMERGENCY	11,911,664	1,755,200	13,666,864	-181,260	13,485,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,091,140	1,171,815	4,262,955	-7,661	4,255,294	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		2,178,138	2,178,138	-2,178,138	0	113.00
116.00	11600	HOSPICE	1,191,414	397,512	1,588,926	14,977	1,603,903	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,631,099	262,596,012	400,227,111	-26,455	400,200,656	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,643,565	191,775	1,835,340	0	1,835,340	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	26,455	26,455	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	218,424	734,888	953,312	0	953,312	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	139,493,088	263,522,675	403,015,763	0	403,015,763	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	5,658	36,534	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-4,831,314	368,924	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	3,054,996	6,810,454	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	-58,163	7,993	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	807,694	807,694	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	61,063	61,063	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,561,151	14,025,692	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-29,086,946	19,956,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-75,714,673	52,490,913	5.00
6.00	00600	MAINTENANCE & REPAIRS	-922,626	8,205,879	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,416	1,485,581	8.00
9.00	00900	HOUSEKEEPING	-843,752	3,585,249	9.00
10.00	01000	DIETARY	-1,093,082	1,276,401	10.00
11.00	01100	CAFETERIA	-1,638,329	2,822,637	11.00
13.00	01300	NURSING ADMINISTRATION	-274,274	9,260,392	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,161,000	5,915,616	16.00
20.00	02000	NURSING SCHOOL	-5,117,138	2,285,090	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,116,867	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,098,688	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-83,840	227,190	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-36,305	41,386	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	345,848	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	167,185	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	155,122	23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,217,916	20,324,947	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,276,642	4,028,445	31.00
40.00	04000	SUBPROVIDER - IPF	-5,038	4,449,517	40.00
41.00	04100	SUBPROVIDER - IRF	-9,291	1,876,550	41.00
43.00	04300	NURSERY	0	339,662	43.00
44.00	04400	SKILLED NURSING FACILITY	-628	1,787,846	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,505,763	14,710,123	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	791,448	52.00
53.00	05300	ANESTHESIOLOGY	-2,278	563,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,280,170	5,008,099	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,436,004	55.00
57.00	05700	CT SCAN	0	957,438	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	732,872	58.00
60.00	06000	LABORATORY	-1,710	7,416,478	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,449,678	62.00
65.00	06500	RESPIRATORY THERAPY	-13,951	2,380,063	65.00
66.00	06600	PHYSICAL THERAPY	0	1,459,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	862,239	67.00
68.00	06800	SPEECH PATHOLOGY	0	261,389	68.00
69.00	06900	ELECTROCARDIOLOGY	-10,893	2,850,115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-29,108	561,210	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-45,194	12,140,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,291,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,985,267	20,392,169	73.00
74.00	07400	RENAL DIALYSIS	0	845,580	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-49,419	835,032	88.00
90.00	09000	CLINIC	0	532,958	90.00
90.01	09001	OUTPATIENT INFUSION	0	532,655	90.01
91.00	09100	EMERGENCY	-7,679,711	5,805,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-10,490	4,244,804	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	174,788	1,778,691	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-130,998,977	269,201,679	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,835,340	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	26,455	193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.04	19304	RENTED SPACE	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	953,312	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-130,998,977	272,016,786	200.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,679,630	2,781,336		1.00
	TOTALS		1,679,630	2,781,336		
	B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	11,104	0		1.00
	TOTALS		11,104	0		
	D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	30,220		1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	58,044		2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	83,842		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,297		4.00
	TOTALS		0	193,403		
	E - RECLASS VOLUNTEER SERVICES					
1.00	HOSPICE	116.00	12,219	3,123		1.00
	TOTALS		12,219	3,123		
	F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.03	26,376	79		1.00
	TOTALS		26,376	79		
	G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1,956,965		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,904		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	208,269		3.00
	TOTALS		0	2,178,138		
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,276,228		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,291,803		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
	TOTALS		0	24,568,031		
	J - RECLASS PRECEPTOR PAY					
1.00	NURSING SCHOOL	20.00	847,327	0		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
	TOTALS		847,327	0		

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - RECLASS RENT EXPENSE				
1.00	CAP REL COSTS-MOB PHASE I	1.04	0	66,156	1.00
	TOTALS		0	66,156	
	L - RECLASS LEASEHOLD IMP DEPR				
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	28,373	1.00
2.00	RESPIRATORY THERAPY	65.00	0	12,491	2.00
3.00	LABORATORY	60.00	0	11,913	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	5,623	4.00
	TOTALS		0	58,400	
	M - RECLASS OTHER PARAMEDIC PROGRAMS				
1.00	PARAMED ED PRGM-RESPIRATORY	23.04	140,446	26,739	1.00
2.00	PARAMED ED PRGM-HIM	23.05	84,233	70,889	2.00
	TOTALS		224,679	97,628	
	N - RECLASS CONTRACTED HOUSEKEEPING				
1.00	HOSPICE	116.00	0	3,927	1.00
2.00	HOUSEKEEPING	9.00	0	79,178	2.00
	TOTALS		0	83,105	
500.00	Grand Total: Increases		2,801,335	30,029,399	500.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,679,630	2,781,336	0		1.00
	TOTALS		1,679,630	2,781,336			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11,104	0	0		1.00
	TOTALS		11,104	0			
	D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	193,403	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	193,403			
	E - RECLASS VOLUNTEER SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	12,219	3,123	0		1.00
	TOTALS		12,219	3,123			
	F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	26,376	79	0		1.00
	TOTALS		26,376	79			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,178,138	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	2,178,138			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	17,653	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	110,201	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,307	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	605	0		4.00
5.00	NURSERY	43.00	0	25,080	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	789	0		6.00
7.00	OPERATING ROOM	50.00	0	15,252,716	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	123,168	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	292,014	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	295,707	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	11,209	0		11.00
12.00	CT SCAN	57.00	0	35,623	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	336	0		13.00
14.00	LABORATORY	60.00	0	134,987	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	311,329	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	1,846	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	414	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	1,778	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	7,833,336	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,921	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	538	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	1,158	0		22.00
23.00	CLINIC	90.00	0	221	0		23.00
24.00	OUTPATIENT INFUSION	90.01	0	1,879	0		24.00
25.00	EMERGENCY	91.00	0	104,494	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	7,661	0		26.00
27.00	HOSPICE	116.00	0	61	0		27.00
	TOTALS		0	24,568,031			
	J - RECLASS PRECEPTOR PAY						
1.00	NURSING ADMINISTRATION	13.00	56,783	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	415,228	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	98,680	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	30,533	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	21,322	0	0		5.00
6.00	ANESTHESIOLOGY	53.00	46,694	0	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	23,701	0	0		7.00
8.00	OPERATING ROOM	50.00	48,942	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	21,551	0	0		9.00
10.00	RESPIRATORY THERAPY	65.00	2,896	0	0		10.00
11.00	EMERGENCY	91.00	76,766	0	0		11.00
12.00	HOSPICE	116.00	4,231	0	0		12.00
	TOTALS		847,327	0			
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,156	10		1.00
	TOTALS		0	66,156			
	L - RECLASS LEASEHOLD IMP DEPR						
1.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	58,400	9		1.00
2.00		0.00	0	0	0		2.00

RECLASSIFICATIONS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	58,400		
M - RECLASS OTHER PARAMEDIC PROGRAMS						
1.00	NURSING SCHOOL	20.00	224,679	97,628	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		224,679	97,628		
N - RECLASS CONTRACTED HOUSEKEEPING						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,105	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	83,105		
500.00	Grand Total: Decreases		2,801,335	30,029,399		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	14,452,937	265,004	0	265,004	0	1.00	
2.00	Land Improvements	8,032,867	155,314	0	155,314	68,086	2.00	
3.00	Buildings and Fixtures	139,965,837	1,376,253	0	1,376,253	989,392	3.00	
4.00	Building Improvements	3,564,673	0	0	0	33,491	4.00	
5.00	Fixed Equipment	76,392,798	3,628,986	0	3,628,986	182,479	5.00	
6.00	Movable Equipment	169,175,890	13,094,608	0	13,094,608	986,235	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	411,585,002	18,520,165	0	18,520,165	2,259,683	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	411,585,002	18,520,165	0	18,520,165	2,259,683	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	14,717,941	0					1.00
2.00	Land Improvements	8,120,095	0					
3.00	Buildings and Fixtures	140,352,698	0					
4.00	Building Improvements	3,531,182	0					4.00
5.00	Fixed Equipment	79,839,305	0					
6.00	Movable Equipment	181,284,263	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	427,845,484	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	427,845,484	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	656	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	5,200,594	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,714,651	0	0	0	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	11,430,340	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	18,346,241	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	656				1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	5,200,594				1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,714,651				1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0				1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0				1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0				1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,430,340				2.00
3.00	Total (sum of lines 1-2)	0	18,346,241				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	41,946	0	41,946	0.000104	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	175,800,833	0	175,800,833	0.434068	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	47,880,406	0	47,880,406	0.118221	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0.000000	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	181,284,263	0	181,284,263	0.447607	0	2.00
3.00	Total (sum of lines 1-2)	405,007,448	0	405,007,448	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	6,314	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	310,880	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	6,726,613	0	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	7,993	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	752,934	54,760	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	61,063	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,004,395	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,862,199	62,753	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	30,220	0	0	36,534	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	58,044	0	0	368,924	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	-1	83,842	0	0	6,810,454	1.03
1.04	CAP REL COSTS-MOB PHASE I	0	0	0	0	7,993	1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0	807,694	1.05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	61,063	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,297	0	0	14,025,692	2.00
3.00	Total (sum of lines 1-2)	-1	193,403	0	0	22,118,354	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			0CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)			0CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			0CAP REL COSTS-MOB PHASE I	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-OAK STREET MALL (chapter 2)			0CAP REL COSTS-OAK STREET MALL	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BRCN AT 36TH ST (chapter 2)			0CAP REL COSTS-BRCN AT 36TH ST	1.06	0	1.06
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-219,805	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-19,635	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-29,349,082			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	14,701,323			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,638,329	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-2,708,359	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-84,222	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-5,016,608	NURSING SCHOOL	20.00	0	19.00
20.00	Vending machines	B	-24,506	DIETARY	10.00	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0 CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING			0 CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES			0 CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES			0 CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-MOB PHASE I			0 CAP REL COSTS-MOB PHASE I	1.04	0	26.04
26.05	Depreciation - CAP REL COSTS-OAK STREET MALL			0 CAP REL COSTS-OAK STREET MALL	1.05	0	26.05
26.06	Depreciation - CAP REL COSTS-BRCN AT 36TH ST			0 CAP REL COSTS-BRCN AT 36TH ST	1.06	0	26.06
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
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	RENTAL INSURANCE EXPENSE	A	-12,162	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DAMAGED GOODS	B	8,040	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CHILD CARE CENTER	B	-2,226,625	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	BOOKKEEPING FEES	B	-153,303	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY TUITION	B	-83,840	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.04
33.05	PRINT SHOP	B	-85,950	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HEALTH PROMOTIONS	B	-91,188	NURSING ADMINISTRATION	13.00	0	33.06
33.07	HOUSEKEEPING SERVICES	B	-374,072	HOUSEKEEPING	9.00	0	33.07
33.08	ADVERTISING	A	-229	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	ADVERTISING	A	-933,668	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING	A	-5,929	DIETARY	10.00	0	33.10
33.11	ADVERTISING	A	-40,530	NURSING SCHOOL	20.00	0	33.11
33.12	ADVERTISING	A	-118	SUBPROVIDER - IPF	40.00	0	33.12
33.13	ADVERTISING	A	-2,429	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	ADVERTISING	A	-135	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	ADVERTISING	A	-10,490	HOME HEALTH AGENCY	101.00	0	33.15
33.16	RENTAL PROPERTY EXPENSE	A	-141,781	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.16
33.17	REAL ESTATE TAXES ON RENTAL	A	-117,706	MAINTENANCE & REPAIRS	6.00	0	33.17
33.18	RENTAL PROPERTY EXPENSE	A	-28,564	MAINTENANCE & REPAIRS	6.00	0	33.18
33.19	INTEREST INCOME	A	-1,956,966	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.19
33.20	INTEREST INCOME	A	-12,904	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.20
33.21	INTEREST INCOME	A	-208,269	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	DIETARY OUTSIDE SERVICES-SALARIES	A	-49,898	DIETARY	10.00	0	33.22
33.23	DIETARY OUTSIDE SERVICES-BENEFITS	A	-16,027	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	PHYSICIAN RECRUITMENT	A	-358,914	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	LOBBYING EXPENSE	A	-47,822	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	TRANSFER TO PARENT	A	-8,655,638	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HOSPICE PROFESSIONAL FEES	A	-4,169	HOSPICE	116.00	0	33.27
33.28	ER PHYSICIAN BENEFITS	A	-457,586	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	BOOK TO MEDICARE DEPRECIATION	A	40,874	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.30
33.31	GROUND FEES	B	-68,697	MAINTENANCE & REPAIRS	6.00	0	33.31
33.32	LABORATORY TUITION	B	-36,305	PARAMED ED PRGM-LABORATORY	23.02	0	33.32
33.33	CV SURGEON BENEFITS	A	-52,618	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.33
33.34	SELF-FUNDED HEALTH INSURANCE	A	-16,211,395	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.34
33.35	TRAUMA ON-CALL	A	-1,214,846	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	NON-HOSPITAL DEPRECIATION	A	-265,229	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.36

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00		4.00	5.00
33.37	MISCELLANEOUS INCOME	B	-71,762	ADMINISTRATIVE & GENERAL		5.00	0 33.37
33.38	MISCELLANEOUS INCOME	B	-7,986	RESPIRATORY THERAPY		65.00	0 33.38
33.39	MISCELLANEOUS INCOME	B	-8,869	ADMINISTRATIVE & GENERAL		5.00	0 33.39
33.40	MISCELLANEOUS INCOME	B	-529,495	ADMINISTRATIVE & GENERAL		5.00	0 33.40
33.41	MISCELLANEOUS INCOME	B	-400,000	DIETARY		10.00	0 33.41
33.42	MISCELLANEOUS INCOME	B	-1,710	LABORATORY		60.00	0 33.42
33.43	MISCELLANEOUS INCOME	B	-8,796	DRUGS CHARGED TO PATIENTS		73.00	0 33.43
33.44	MISCELLANEOUS INCOME	B	-1,459	ELECTROCARDIOLOGY		69.00	0 33.44
33.45	MISCELLANEOUS INCOME	B	-15,137	RADIOLOGY-DIAGNOSTIC		54.00	0 33.45
33.46	DOCTORS LOUNGE REVENUE	B	-81,837	DIETARY		10.00	0 33.46
33.47	CARE COORDINATION	B	-46,901	ADMINISTRATIVE & GENERAL		5.00	0 33.47
33.48	MISCELLANEOUS INCOME	B	-505,546	ADMINISTRATIVE & GENERAL		5.00	0 33.48
33.49	MISCELLANEOUS INCOME	B	3,802	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 33.49
33.50	OUTSIDE CATERING	B	-30,367	DIETARY		10.00	0 33.50
33.51	BH JAVA	B	-496,161	DIETARY		10.00	0 33.51
33.52	BPS EXPENSES	A	-38,556,839	ADMINISTRATIVE & GENERAL		5.00	0 33.52
33.53	PHARMACY COVERAGE SALARES	A	-64,255	DRUGS CHARGED TO PATIENTS		73.00	0 33.53
33.54	PHARMACY COVERAGE BENEFITS	A	-20,282	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.54
33.55	PHARMACY COVERAGE EXPENSES	A	-38,144	DRUGS CHARGED TO PATIENTS		73.00	0 33.55
33.56	INFORMATION SYSTEMS WAGES	A	-6,589,296	ADMINISTRATIVE & GENERAL		5.00	0 33.56
33.57	INFORMATION SYSTEM EXPENSES	A	-9,094,193	ADMINISTRATIVE & GENERAL		5.00	0 33.57
33.58	INTEREST FROM INSURANCE	B	-558,420	ADMINISTRATIVE & GENERAL		5.00	0 33.58
33.59	PAIN MANAGEMENT NP SALARIES	A	-57,180	OPERATING ROOM		50.00	0 33.59
33.60	PAIN MANAGEMENT NP BENEFITS	A	-18,366	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.60
33.61	PAIN MANAGEMENT NP EXPENSES	A	3	OPERATING ROOM		50.00	0 33.61
33.62	PA AND NP IN EMERGENCY DEPARTMENT	A	-512,956	EMERGENCY		91.00	0 33.62
33.63	PA AND NP IN ADULTS AND PEDS	A	-811,129	ADULTS & PEDIATRICS		30.00	0 33.63
33.64	PA AND NP BENEFITS	A	-164,761	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.64
33.65	COLLEGE OF NURSING LOBBYING	A	-60,000	NURSING SCHOOL		20.00	0 33.65
33.66	LOBBYING EXPENSE	A	-2,576	SUBPROVIDER - IRF		41.00	0 33.66
33.67	HIM SALARIES	A	-3,736,036	MEDICAL RECORDS & LIBRARY		16.00	0 33.67
33.68	PFS AND PT ACCESS SALARIES	A	-5,612,461	ADMINISTRATIVE & GENERAL		5.00	0 33.68
33.69	HIM EXPENSES	A	-1,018,580	MEDICAL RECORDS & LIBRARY		16.00	0 33.69
33.70	PFS AND PT ACCESS EXPENSES	A	-3,415,649	ADMINISTRATIVE & GENERAL		5.00	0 33.70
33.71	DECISION SUPPORT SALARIES	A	-834,286	ADMINISTRATIVE & GENERAL		5.00	0 33.71
33.72	DECISION SUPPORT EXPENSES	A	-57,788	ADMINISTRATIVE & GENERAL		5.00	0 33.72
33.73	HUMAN RESOURCES SALARIES	A	-836,431	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.73
33.74	HUMAN RESOURCES EXPENSES	A	-844,638	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.74
33.75	MISCELLANEOUS INCOME	B	-165,713	DRUGS CHARGED TO PATIENTS		73.00	0 33.75
33.76	MISCELLANEOUS INCOME	B	-3,713	MAINTENANCE & REPAIRS		6.00	0 33.76
33.77	MISCELLANEOUS INCOME	B	-19,898	EMERGENCY		91.00	0 33.77
33.78	HOSPICE RESPITE AND INPATIENT PMT	A	3,721	HOSPICE		116.00	0 33.78
33.79	HOSPITAL SERVICES TO HOSPICE PATIENT	A	175,236	HOSPICE		116.00	0 33.79
33.80	ONCOLOGIST BENEFITS	A	-167,202	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.80
33.81	HOSPITALIST BENEFITS	A	-177,345	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.81
33.82	DEPRECIATION ADJUSTMENT	A	5,658	CAP REL COSTS-BUTLER BUILDING		1.01	9 33.82
33.83	DEPRECIATION ADJUSTMENT	A	-4,825,068	CAP REL COSTS-OLD BLDG & FIXTURES		1.02	9 33.83
33.84	DEPRECIATION ADJUSTMENT	A	5,858,301	CAP REL COSTS-NEW BLDG & FIXTURES		1.03	9 33.84
33.85	DEPRECIATION ADJUSTMENT	A	752,934	CAP REL COSTS-OAK STREET MALL		1.05	9 33.85
33.86	DEPRECIATION ADJUSTMENT	A	61,063	CAP REL COSTS-BRCN AT 36TH ST		1.06	9 33.86
33.87	DEPRECIATION ADJUSTMENT	A	2,870,848	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.87
33.88	DEPRECIATION ADJUSTMENT	A	-745,432	CAP REL COSTS-NEW BLDG & FIXTURES		1.03	9 33.88
33.89	DEPRECIATION ADJUSTMENT	A	-6,246	CAP REL COSTS-OLD BLDG & FIXTURES		1.02	9 33.89
33.90	CORPORATE FEES-BPS	B	-119,186	ADMINISTRATIVE & GENERAL		5.00	0 33.90
33.91	CONTRACTED HOUSEKEEPING	A	-469,680	HOUSEKEEPING		9.00	0 33.91
33.92	COMMUNITY BENEFIT	A	-681,457	ADMINISTRATIVE & GENERAL		5.00	0 33.92
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-130,998,977				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
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Worksheet A-8

Date/Time Prepared:
2/27/2020 10:31 pm

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

(1) 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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 10:31 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED MAINTENANCE	638,183	1,342,129	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	BIO-MED MAINTENANCE	20	44	2.00
3.00	50.00	OPERATING ROOM	BIO-MED MAINTENANCE	6,856	14,419	3.00
4.00	53.00	ANESTHESIOLOGY	BIO-MED MAINTENANCE	2,066	4,344	4.00
4.01	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,414,863	1,416,279	4.01
4.02	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	81,247	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	35,567,587	17,740,602	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5,999,862	0	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	7,801,935	4.05
4.06	1.04	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	11,554	69,717	4.06
4.07	10.00	DIETARY	DIETICIAN COSTS	0	4,384	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	1,408	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	5,467	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	1,756	4.10
4.11	13.00	NURSING ADMINISTRATION	CARE MANAGEMENT COSTS	0	183,086	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	CARE MANAGEMENT BENEFITS	0	58,807	4.12
4.13	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY WAGES	0	22,535	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDY BENEFITS	0	7,238	4.14
4.15	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDY EXPENSES	0	3,336	4.15
4.16	30.00	ADULTS & PEDIATRICS	TELEMETRY WAGES	0	20,421	4.16
4.17	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	6,559	4.17
4.18	71.00	MEDICAL SUPPLIES CHARGED TO	PURCHASING AGENT WAGES	0	48,996	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING AGENT BENEFITS	0	15,738	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	OAK STREET MALL	0	164,015	4.20
4.21	1.05	CAP REL COSTS-OAK STREET MAL	OAK STREET MALL	110,177	0	4.21
4.22	1.05	CAP REL COSTS-OAK STREET MAL	BCC RENT FOR HIM, PFS, PA	0	55,417	4.22
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	0	11,929	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			43,783,131	29,081,808	5.00

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

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

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

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

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

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 10:31 pm

	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	-703,946	0		1.00
2.00	-24	0		2.00
3.00	-7,563	0		3.00
4.00	-2,278	0		4.00
4.01	-1,416	0		4.01
4.02	-49,284	0		4.02
4.03	17,826,985	0		4.03
4.04	5,999,862	0		4.04
4.05	-7,801,935	0		4.05
4.06	-58,163	10		4.06
4.07	-4,384	0		4.07
4.08	-1,408	0		4.08
4.09	-5,467	0		4.09
4.10	-1,756	0		4.10
4.11	-183,086	0		4.11
4.12	-58,807	0		4.12
4.13	-22,535	0		4.13
4.14	-7,238	0		4.14
4.15	-3,336	0		4.15
4.16	-20,421	0		4.16
4.17	-6,559	0		4.17
4.18	-48,996	0		4.18
4.19	-15,738	0		4.19
4.20	-164,015	0		4.20
4.21	110,177	10		4.21
4.22	-55,417	10		4.22
4.23	-11,929	9		4.23
5.00	14,701,323			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	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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- 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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 10:31 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,402,925	3,115,275	287,650	211,500	1,919	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	800	800	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	478,746	478,746	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	2,893,416	2,893,416	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	13,711	0	13,711	211,500	98	5.00
6.00	30.00	ADULTS & PEDIATRICS	32,625	0	32,625	211,500	218	6.00
7.00	31.00	INTENSIVE CARE UNIT	1,138,264	1,138,264	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	67,762	67,762	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	70,616	70,616	0	0	0	9.00
10.00	40.00	SUBPROVIDER - IPF	9,540	0	9,540	181,300	53	10.00
11.00	41.00	SUBPROVIDER - IRF	36,000	0	36,000	211,500	288	11.00
12.00	44.00	SKILLED NURSING FACILITY	1,950	0	1,950	211,500	13	12.00
13.00	50.00	OPERATING ROOM	24,200	0	24,200	211,500	120	13.00
14.00	65.00	RESPIRATORY THERAPY	11,700	0	11,700	211,500	78	14.00
15.00	65.00	RESPIRATORY THERAPY	6,975	0	6,975	211,500	47	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	10,050	0	10,050	211,500	67	16.00
17.00	69.00	ELECTROCARDIOLOGY	6,550	0	6,550	211,500	50	17.00
18.00	69.00	ELECTROCARDIOLOGY	15,905	0	15,905	246,400	67	18.00
19.00	91.00	EMERGENCY	31,200	0	31,200	211,500	240	19.00
20.00	91.00	EMERGENCY	205,199	142,799	62,400	211,500	789	20.00
21.00	91.00	EMERGENCY	6,911,821	6,911,821	0	0	0	21.00
22.00	91.00	EMERGENCY	216,612	0	216,612	211,500	1,290	22.00
23.00	50.00	OPERATING ROOM	3,881	0	3,881	211,500	23	23.00
24.00	50.00	OPERATING ROOM	33,488	0	33,488	246,400	74	24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	11,596,095	11,596,095	0	0	0	25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	1,262,604	1,262,604	0	0	0	26.00
27.00	50.00	OPERATING ROOM	383,238	383,238	0	0	0	27.00
28.00	50.00	OPERATING ROOM	1,019,523	1,019,523	0	0	0	28.00
200.00			29,885,396	29,080,959	804,437		5,434	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	195,129	9,756	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	9,965	498	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	22,167	1,108	0	0	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	9.00
10.00	40.00	SUBPROVIDER - IPF	4,620	231	0	0	0	10.00
11.00	41.00	SUBPROVIDER - IRF	29,285	1,464	0	0	0	11.00
12.00	44.00	SKILLED NURSING FACILITY	1,322	66	0	0	0	12.00
13.00	50.00	OPERATING ROOM	12,202	610	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	7,931	397	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	4,779	239	0	0	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	6,813	341	0	0	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	5,084	254	0	0	0	17.00
18.00	69.00	ELECTROCARDIOLOGY	7,937	397	0	0	0	18.00
19.00	91.00	EMERGENCY	24,404	1,220	0	0	0	19.00
20.00	91.00	EMERGENCY	80,228	4,011	0	0	0	20.00
21.00	91.00	EMERGENCY	0	0	0	0	0	21.00
22.00	91.00	EMERGENCY	131,171	6,559	0	0	0	22.00
23.00	50.00	OPERATING ROOM	2,339	117	0	0	0	23.00
24.00	50.00	OPERATING ROOM	8,766	438	0	0	0	24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	26.00
27.00	50.00	OPERATING ROOM	0	0	0	0	0	27.00
28.00	50.00	OPERATING ROOM	0	0	0	0	0	28.00
200.00			554,142	27,706	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	195,129	92,521	3,207,796		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	800		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	478,746		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,893,416		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	9,965	3,746	3,746		5.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 10:31 pm

	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		
6.00	30.00	ADULTS & PEDIATRICS	0	22,167	10,458	10,458		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,138,264		7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	67,762		8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	70,616		9.00
10.00	40.00	SUBPROVIDER - IPF	0	4,620	4,920	4,920		10.00
11.00	41.00	SUBPROVIDER - IRF	0	29,285	6,715	6,715		11.00
12.00	44.00	SKILLED NURSING FACILITY	0	1,322	628	628		12.00
13.00	50.00	OPERATING ROOM	0	12,202	11,998	11,998		13.00
14.00	65.00	RESPIRATORY THERAPY	0	7,931	3,769	3,769		14.00
15.00	65.00	RESPIRATORY THERAPY	0	4,779	2,196	2,196		15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	6,813	3,237	3,237		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	5,084	1,466	1,466		17.00
18.00	69.00	ELECTROCARDIOLOGY	0	7,937	7,968	7,968		18.00
19.00	91.00	EMERGENCY	0	24,404	6,796	6,796		19.00
20.00	91.00	EMERGENCY	0	80,228	0	142,799		20.00
21.00	91.00	EMERGENCY	0	0	0	6,911,821		21.00
22.00	91.00	EMERGENCY	0	131,171	85,441	85,441		22.00
23.00	50.00	OPERATING ROOM	0	2,339	1,542	1,542		23.00
24.00	50.00	OPERATING ROOM	0	8,766	24,722	24,722		24.00
25.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,596,095		25.00
26.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,262,604		26.00
27.00	50.00	OPERATING ROOM	0	0	0	383,238		27.00
28.00	50.00	OPERATING ROOM	0	0	0	1,019,523		28.00
200.00			0	554,142	268,123	29,349,082		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	36,534	0	36,534		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	368,924	0	0	368,924	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	6,810,454	0	0	0	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	7,993	0	0	6,810,454	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	807,694	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	61,063	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,025,692				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,956,350	0	0	13,309	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,490,913	0	6,323	85,447	5.00
6.00	00600	MAINTENANCE & REPAIRS	8,205,879	0	0	60,129	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,485,581	0	0	5,829	8.00
9.00	00900	HOUSEKEEPING	3,585,249	0	0	11,982	9.00
10.00	01000	DIETARY	1,276,401	0	0	0	10.00
11.00	01100	CAFETERIA	2,822,637	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,260,392	0	0	12,766	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,915,616	0	0	1,777	16.00
20.00	02000	NURSING SCHOOL	2,285,090	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,116,867	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,098,688	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	227,190	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	41,386	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	345,848	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	167,185	0	0	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	155,122	0	0	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,324,947	0	0	1,941	30.00
31.00	03100	INTENSIVE CARE UNIT	4,028,445	0	0	30,102	31.00
40.00	04000	SUBPROVIDER - IPF	4,449,517	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,876,550	0	0	14,205	41.00
43.00	04300	NURSERY	339,662	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,787,846	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,710,123	0	0	31,694	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	791,448	0	0	25,741	52.00
53.00	05300	ANESTHESIOLOGY	563,027	0	0	1,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,008,099	0	0	4,629	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,436,004	0	0	0	55.00
57.00	05700	CT SCAN	957,438	0	0	1,813	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	732,872	0	0	0	58.00
60.00	06000	LABORATORY	7,416,478	0	0	1,941	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,449,678	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,380,063	0	0	5,537	65.00
66.00	06600	PHYSICAL THERAPY	1,459,810	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	862,239	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	261,389	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,850,115	0	0	24,410	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	561,210	0	0	5,400	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,140,386	0	12,646	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,291,803	0	17,565	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,392,169	0	0	905	73.00
74.00	07400	RENAL DIALYSIS	845,580	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	835,032	0	0	0	88.00
90.00	09000	CLINIC	532,958	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	532,655	0	0	0	90.01
91.00	09100	EMERGENCY	5,805,893	0	0	16,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				170,871	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,244,804	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,778,691	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,201,679	0	36,534	357,944	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8,920	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,835,340	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	11,305	193.01
193.02	19302	UNUSED SPACE	0	0	0	386	308,120	193.02
193.03	19303	HEALTH EDUCATION	26,455	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	1,674	282,875	193.04
193.05	19305	AUGUSTA PHARMACY	953,312	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	272,016,786	0	36,534	368,924	6,810,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
GENERAL SERVICE COST CENTERS			4.00					
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	7,993					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	807,694				1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	61,063			1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP				14,025,692		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	122,212	20,154,074	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,993	518,974	0	4,851,882	2,044,734	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,075	0	337,763	545,436	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,128	7,954	8.00
9.00	00900	HOUSEKEEPING	0	418	0	86,946	502,476	9.00
10.00	01000	DIETARY	0	0	0	182,308	159,957	10.00
11.00	01100	CAFETERIA	0	0	0	0	320,656	11.00
13.00	01300	NURSING ADMINISTRATION	0	55,376	0	729,806	1,603,317	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,791	0	67,999	0	16.00
20.00	02000	NURSING SCHOOL	0	77,116	59,160	154,976	850,913	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	213,220	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	750	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,195	0	2,928	56,017	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,686	13,803	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	63,361	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	620	476	1,245	26,812	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	1,859	1,427	3,735	16,081	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,454,180	3,295,630	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	147,059	709,630	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	8,080	813,262	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	13,456	293,087	41.00
43.00	04300	NURSERY	0	0	0	25,755	50,182	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,006	298,335	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,384,170	1,791,956	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	29,011	121,516	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	122,922	43,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	644,328	644,694	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	634,570	224,411	55.00
57.00	05700	CT SCAN	0	0	0	127,676	109,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	30,289	62,761	58.00
60.00	06000	LABORATORY	0	0	0	248,441	649,090	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	15,744	27,982	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	403,495	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,987	273,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,081	163,042	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,642	48,832	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	772,180	404,806	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	51,939	82,977	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,729	62,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	99,789	99,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	301,409	816,511	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,656	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	86,764	88.00
90.00	09000	CLINIC	0	0	0	0	85,603	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	87,061	90.01
91.00	09100	EMERGENCY	0	31,049	0	174,992	800,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	27,614	0	641	590,126	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	10,110	228,977	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		7,993	799,087	61,063	13,940,206	19,793,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	82,245	313,771	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	144	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
			1.04	1.05	1.06	2.00	4.00	
193.02	19302	UNUSED SPACE	0	8,607	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	5,035	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	3,097	41,699	193.05
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)	7,993	807,694	61,063	14,025,692	20,154,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,286,455	61,286,455				5.00
6.00	00600	MAINTENANCE & REPAIRS	9,964,609	2,897,997	12,862,606			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,519,557	441,931	77,731	2,039,219		8.00
9.00	00900	HOUSEKEEPING	4,203,181	1,222,407	125,696	20,644	5,571,928	9.00
10.00	01000	DIETARY	1,792,285	521,248	357,398	15,017	187,244	10.00
11.00	01100	CAFETERIA	3,211,703	934,056	140,823	0	73,785	11.00
13.00	01300	NURSING ADMINISTRATION	11,670,928	3,394,244	212,572	0	111,373	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,084,554	1,769,565	197,631	0	103,528	16.00
20.00	02000	NURSING SCHOOL	3,608,720	1,049,520	871,584	0	456,614	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,330,087	386,828	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,099,438	610,577	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	311,164	90,496	45,172	0	23,685	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	63,709	18,528	12,009	0	6,306	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	409,209	119,010	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	197,796	57,525	7,005	0	3,674	23.04
23.05	02305	PARAMED ED PRGM-HIM	182,599	53,105	20,992	0	11,023	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,515,918	7,711,562	2,977,545	682,888	1,560,066	30.00
31.00	03100	INTENSIVE CARE UNIT	5,042,265	1,466,437	492,147	114,288	257,851	31.00
40.00	04000	SUBPROVIDER - IPF	5,676,523	1,650,898	835,069	25,295	437,498	40.00
41.00	04100	SUBPROVIDER - IRF	2,251,282	654,738	219,973	110,888	115,246	41.00
43.00	04300	NURSERY	455,926	132,597	83,014	12,363	43,497	43.00
44.00	04400	SKILLED NURSING FACILITY	2,218,048	645,073	269,381	81,296	141,116	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,235,435	5,594,222	896,416	162,014	469,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	967,716	281,440	197,236	56,323	103,329	52.00
53.00	05300	ANESTHESIOLOGY	738,676	214,828	30,394	0	15,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,478,794	1,884,221	399,917	147,946	209,538	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,421,233	704,165	259,886	79,549	136,150	55.00
57.00	05700	CT SCAN	1,207,740	351,246	37,958	50,291	19,911	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	848,409	246,742	46,289	11,916	24,231	58.00
60.00	06000	LABORATORY	8,431,368	2,452,086	252,462	200	132,277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,497,757	435,591	8,960	0	4,717	62.00
65.00	06500	RESPIRATORY THERAPY	2,789,095	811,150	42,426	0	22,245	65.00
66.00	06600	PHYSICAL THERAPY	1,778,973	517,377	79,080	0	41,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,046,926	304,476	38,214	0	20,010	67.00
68.00	06800	SPEECH PATHOLOGY	320,149	93,109	12,940	0	6,803	68.00
69.00	06900	ELECTROCARDIOLOGY	4,105,269	1,193,931	297,704	80,999	155,962	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	701,526	204,024	41,379	617	21,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,359,784	3,594,584	158,906	11,247	83,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,610,007	4,249,014	221,090	15,646	115,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,556,284	6,269,193	100,165	0	52,484	73.00
74.00	07400	RENAL DIALYSIS	853,236	248,146	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	921,796	268,085	0	0	0	88.00
90.00	09000	CLINIC	618,561	179,895	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	659,274	191,736	81,431	670	42,652	90.01
91.00	09100	EMERGENCY	6,999,864	2,035,763	531,664	352,440	278,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,863,185	1,414,355	47,709	0	24,976	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,017,778	586,828	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	268,124,791	60,154,549	10,727,968	2,032,537	5,514,181	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,930	5,215	86,900	6,682	45,532	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,231,356	648,943	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	11,449	3,330	23,273	0	12,215	193.01
193.02	19302	UNUSED SPACE	317,113	92,226	652,100	0	0	193.02
193.03	19303	HEALTH EDUCATION	31,490	9,158	0	0	0	193.03
193.04	19304	RENTED SPACE	284,549	82,755	1,372,365	0	0	193.04

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
193.05	19305	AUGUSTA PHARMACY	998,108	290,279	0	0	0	193.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	272,016,786	61,286,455	12,862,606	2,039,219	5,571,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,873,192					10.00
11.00	01100	CAFETERIA	0	4,360,367				11.00
13.00	01300	NURSING ADMINISTRATION	0	413,305	15,802,422			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,155,278		16.00
20.00	02000	NURSING SCHOOL	0	194,173	0	0	6,180,611	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	60,728	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	12,598	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,266	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	11,689	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	6,976	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	0	1,592	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,730,701	1,071,930	6,159,672	4,886,556	4,498,864	30.00
31.00	03100	INTENSIVE CARE UNIT	198,852	186,494	1,071,632	561,437	376,641	31.00
40.00	04000	SUBPROVIDER - IPF	503,286	263,273	1,512,827	1,420,986	438,928	40.00
41.00	04100	SUBPROVIDER - IRF	188,941	80,303	461,456	533,472	39,903	41.00
43.00	04300	NURSERY	0	11,358	65,243	12,277	97,713	43.00
44.00	04400	SKILLED NURSING FACILITY	251,412	97,634	561,048	709,811	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	487,913	2,803,646	0	215,474	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	34,467	198,035	0	285,741	52.00
53.00	05300	ANESTHESIOLOGY	0	16,164	92,864	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	172,594	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	48,636	0	0	0	55.00
57.00	05700	CT SCAN	0	26,530	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,955	0	0	0	58.00
60.00	06000	LABORATORY	0	236,681	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10,046	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	114,046	0	0	1,557	65.00
66.00	06600	PHYSICAL THERAPY	0	59,684	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,524	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,531	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	96,528	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,664	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,770	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,688	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	157,949	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	19,492	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	23,636	135,799	0	5,450	90.01
91.00	09100	EMERGENCY	0	270,486	1,554,258	30,739	176,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	842,515	0	17,129	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	343,427	0	26,277	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,873,192	4,359,303	15,802,422	8,155,278	6,180,611	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	1,064	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,873,192	4,360,367	15,802,422	8,155,278	6,180,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
GENERAL SERVICE COST CENTERS			21.00	22.00	23.00	23.01	23.02	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,777,643					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,710,015				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				483,115		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					103,818	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM						23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,226,974	1,870,521	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	45,419	69,241	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	53,676	81,830	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	37,161	56,651	0	0	0	41.00
43.00	04300	NURSERY	49,548	75,535	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,496	102,897	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,735	20,939	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,129	6,295	0	483,115	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,477	8,350	0	0	103,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	63,367	96,603	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53,676	81,830	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	156,985	239,323	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,777,643	2,710,015	0	483,115	103,818	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	1,777,643	2,710,015	0	483,115	103,818	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATO RY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	539,908					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		272,976				23.04
23.05	02305	PARAMED ED PRGM-HIM			269,311			23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	161,369	61,054,566	-3,097,495	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	18,540	9,901,244	-114,660	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	46,925	12,947,014	-135,506	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	17,617	4,767,631	-93,812	41.00
43.00	04300	NURSERY	0	0	405	1,039,476	-125,083	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	23,440	4,998,259	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	30,035,186	-170,393	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,124,287	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,143,539	-34,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,786,549	-10,424	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,649,619	0	55.00
57.00	05700	CT SCAN	0	0	0	1,693,676	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,192,542	0	58.00
60.00	06000	LABORATORY	0	0	0	11,622,719	-13,827	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,957,071	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	272,976	0	4,053,495	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,476,525	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,446,150	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	443,532	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,090,363	-159,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,131,415	-135,506	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,239,560	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,260,287	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	539,908	0	0	28,675,983	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,101,382	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,189,881	0	88.00
90.00	09000	CLINIC	0	0	0	817,948	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	1,140,648	0	90.01
91.00	09100	EMERGENCY	0	0	1,015	12,628,028	-396,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	7,209,869	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	2,974,310	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,908	272,976	269,311	264,792,754	-4,487,658	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	162,259	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,880,299	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	50,267	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
193.02	19302	UNUSED SPACE	0	0	0	1,061,439	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	41,712	0	193.03
193.04	19304	RENTED SPACE	0	0	0	1,739,669	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	1,288,387	0	193.05
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)	539,908	272,976	269,311	272,016,786	-4,487,658	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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To 09/30/2019Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT INFUSION	90.01
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			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	UNUSED SPACE	193.02
193.03	19303	HEALTH EDUCATION	193.03
193.04	19304	RENTED SPACE	193.04
193.05	19305	AUGUSTA PHARMACY	193.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	267,529,128	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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Part II
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Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES		NEW BLDG & FIXTURES
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,812	0	0	13,309	62,203	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,298,245	0	6,323	85,447	1,280,189	5.00
6.00	00600	MAINTENANCE & REPAIRS	459	0	0	60,129	809,327	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	5,829	16,065	8.00
9.00	00900	HOUSEKEEPING	0	0	0	11,982	16,110	9.00
10.00	01000	DIETARY	8,275	0	0	0	173,619	10.00
11.00	01100	CAFETERIA	0	0	0	0	68,410	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	12,766	9,271	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,777	38,371	16.00
20.00	02000	NURSING SCHOOL	276,994	0	0	0	181,465	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	5,834	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	5,834	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	0	1,458	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	0	4,375	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	83,163	0	0	1,941	1,439,220	30.00
31.00	03100	INTENSIVE CARE UNIT	17,323	0	0	30,102	127,029	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	405,664	40.00
41.00	04100	SUBPROVIDER - IRF	1,715	0	0	14,205	53,984	41.00
43.00	04300	NURSERY	0	0	0	0	40,327	43.00
44.00	04400	SKILLED NURSING FACILITY	11,408	0	0	0	130,861	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,208,197	0	0	31,694	317,492	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	25,741	0	52.00
53.00	05300	ANESTHESIOLOGY	17,664	0	0	1,907	7,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,128	0	0	4,629	177,044	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	126,248	55.00
57.00	05700	CT SCAN	0	0	0	1,813	11,690	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	22,487	58.00
60.00	06000	LABORATORY	241,496	0	0	1,941	115,418	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	4,353	62.00
65.00	06500	RESPIRATORY THERAPY	97,993	0	0	5,537	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	38,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	18,564	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	6,286	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,410	53,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73,468	0	0	5,400	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,772	0	12,646	0	72,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,637	0	17,565	0	101,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	905	45,290	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	38,077	0	0	0	0	88.00
90.00	09000	CLINIC	69,019	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	39,558	90.01
91.00	09100	EMERGENCY	0	0	0	16,480	170,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,081	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	112,369	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,954,295	0	36,534	357,944	6,199,144	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	8,920	9,010	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
				1.00	1.01	1.02	1.03	
193.01	19301	DENMAN SERVICES	0	0	0	0	11,305	193.01
193.02	19302	UNUSED SPACE	0	0	0	386	308,120	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	1,674	282,875	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,954,295	0	36,534	368,924	6,810,454	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description		CAPITAL RELATED COSTS				Subtotal	
		MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
		1.04	1.05	1.06	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	122,212	218,536
5.00	00500	ADMINISTRATIVE & GENERAL	7,993	518,974	0	4,851,882	8,049,053
6.00	00600	MAINTENANCE & REPAIRS	0	6,075	0	337,763	1,213,753
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,128	26,022
9.00	00900	HOUSEKEEPING	0	418	0	86,946	115,456
10.00	01000	DIETARY	0	0	0	182,308	364,202
11.00	01100	CAFETERIA	0	0	0	0	68,410
13.00	01300	NURSING ADMINISTRATION	0	55,376	0	729,806	807,219
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,791	0	67,999	168,938
20.00	02000	NURSING SCHOOL	0	77,116	59,160	154,976	749,711
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	750	750
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	19,195	0	2,928	27,957
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,686	8,520
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	620	476	1,245	3,799
23.05	02305	PARAMED ED PRGM-HIM	0	1,859	1,427	3,735	11,396
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,454,180	2,978,504
31.00	03100	INTENSIVE CARE UNIT	0	0	0	147,059	321,513
40.00	04000	SUBPROVIDER - IPF	0	0	0	8,080	413,744
41.00	04100	SUBPROVIDER - IRF	0	0	0	13,456	83,360
43.00	04300	NURSERY	0	0	0	25,755	66,082
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,006	143,275
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,384,170	3,941,553
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	29,011	54,752
53.00	05300	ANESTHESIOLOGY	0	0	0	122,922	150,158
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	644,328	1,135,129
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	634,570	760,818
57.00	05700	CT SCAN	0	0	0	127,676	141,179
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	30,289	52,776
60.00	06000	LABORATORY	0	0	0	248,441	607,296
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	15,744	20,097
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	103,530
66.00	06600	PHYSICAL THERAPY	0	0	0	6,987	45,403
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,081	21,645
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,642	9,928
69.00	06900	ELECTROCARDIOLOGY	0	0	0	772,180	850,348
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	51,939	130,807
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,729	185,079
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	99,789	257,447
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	301,409	347,604
74.00	07400	RENAL DIALYSIS	0	0	0	7,656	7,656
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	38,077
90.00	09000	CLINIC	0	0	0	0	69,019
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	39,558
91.00	09100	EMERGENCY	0	31,049	0	174,992	393,392
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	27,614	0	641	30,336
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	10,110	122,479
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,993	799,087	61,063	13,940,206	25,356,266
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,930
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	82,245	82,245
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DENMAN SERVICES	0	0	0	144	11,449
193.02	19302	UNUSED SPACE	0	8,607	0	0	317,113

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS				Subtotal	
			MOB PHASE I	OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	284,549	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	3,097	3,097	193.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,993	807,694	61,063	14,025,692	26,072,649	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	218,536					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,171	8,071,224				5.00
6.00	00600	MAINTENANCE & REPAIRS	5,914	381,654	1,601,321			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	86	58,201	9,677	93,986		8.00
9.00	00900	HOUSEKEEPING	5,448	160,986	15,648	951	298,489	9.00
10.00	01000	DIETARY	1,734	68,646	44,494	692	10,031	10.00
11.00	01100	CAFETERIA	3,477	123,011	17,532	0	3,953	11.00
13.00	01300	NURSING ADMINISTRATION	17,385	447,008	26,464	0	5,966	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	233,045	24,604	0	5,546	16.00
20.00	02000	NURSING SCHOOL	9,226	138,218	108,507	0	24,461	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,312	50,944	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	80,411	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	607	11,918	5,624	0	1,269	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	150	2,440	1,495	0	338	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	687	15,673	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	291	7,576	872	0	197	23.04
23.05	02305	PARAMED ED PRGM-HIM	174	6,994	2,613	0	591	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,743	1,015,625	370,690	31,475	83,571	30.00
31.00	03100	INTENSIVE CARE UNIT	7,694	193,124	61,269	5,267	13,813	31.00
40.00	04000	SUBPROVIDER - IPF	8,818	217,417	103,961	1,166	23,437	40.00
41.00	04100	SUBPROVIDER - IRF	3,178	86,226	27,385	5,111	6,174	41.00
43.00	04300	NURSERY	544	17,462	10,335	570	2,330	43.00
44.00	04400	SKILLED NURSING FACILITY	3,235	84,953	33,536	3,747	7,560	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,430	736,736	111,599	7,467	25,160	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,318	37,064	24,555	2,596	5,535	52.00
53.00	05300	ANESTHESIOLOGY	468	28,292	3,784	0	854	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,990	248,144	49,787	6,819	11,225	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,433	92,736	32,354	3,666	7,294	55.00
57.00	05700	CT SCAN	1,183	46,258	4,726	2,318	1,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	681	32,495	5,763	549	1,298	58.00
60.00	06000	LABORATORY	7,038	322,930	31,430	9	7,086	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	303	57,366	1,115	0	253	62.00
65.00	06500	RESPIRATORY THERAPY	4,375	106,825	5,282	0	1,192	65.00
66.00	06600	PHYSICAL THERAPY	2,968	68,136	9,845	0	2,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,768	40,098	4,757	0	1,072	67.00
68.00	06800	SPEECH PATHOLOGY	529	12,262	1,611	0	364	68.00
69.00	06900	ELECTROCARDIOLOGY	4,389	157,236	37,062	3,733	8,355	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	900	26,869	5,151	28	1,162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	673	473,392	19,783	518	4,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,078	559,578	27,524	721	6,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,853	825,627	12,470	0	2,812	73.00
74.00	07400	RENAL DIALYSIS	0	32,680	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	941	35,306	0	0	0	88.00
90.00	09000	CLINIC	928	23,692	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	944	25,251	10,138	31	2,285	90.01
91.00	09100	EMERGENCY	8,681	268,102	66,189	16,244	14,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,399	186,265	5,939	0	1,338	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,483	77,283	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,627	7,922,155	1,335,570	93,678	295,396	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	687	10,819	308	2,439	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,402	85,463	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	439	2,897	0	654	193.01
193.02	19302	UNUSED SPACE	0	12,146	81,183	0	0	193.02
193.03	19303	HEALTH EDUCATION	55	1,206	0	0	0	193.03

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
193.04	19304	RENTED SPACE	0	10,899	170,852	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	452	38,229	0	0	0	193.05
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)	218,536	8,071,224	1,601,321	93,986	298,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	489,799					10.00
11.00	01100	CAFETERIA	0	216,383				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,510	1,324,552			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	432,133		16.00
20.00	02000	NURSING SCHOOL	0	9,636	0	0	1,039,759	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,014	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	625	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	162	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	580	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	346	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	0	79	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	295,036	53,193	516,300	258,928		30.00
31.00	03100	INTENSIVE CARE UNIT	33,899	9,255	89,824	29,750		31.00
40.00	04000	SUBPROVIDER - IPF	85,796	13,065	126,805	75,295		40.00
41.00	04100	SUBPROVIDER - IRF	32,209	3,985	38,679	28,268		41.00
43.00	04300	NURSERY	0	564	5,469	651		43.00
44.00	04400	SKILLED NURSING FACILITY	42,859	4,845	47,027	37,612		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	24,213	235,000	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,710	16,599	0		52.00
53.00	05300	ANESTHESIOLOGY	0	802	7,784	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,565	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,414	0	0		55.00
57.00	05700	CT SCAN	0	1,317	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	742	0	0		58.00
60.00	06000	LABORATORY	0	11,745	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	499	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	5,660	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,962	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,812	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	523	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,790	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,323	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,577	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,416	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,838	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	967	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	1,173	11,383	0		90.01
91.00	09100	EMERGENCY	0	13,423	130,277	1,629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	70,619	0		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0		113.00
116.00	11600	HOSPICE	0	0	28,786	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	489,799	216,330	1,324,552	432,133	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	DENMAN SERVICES	0	0	0	0		193.01
193.02	19302	UNUSED SPACE	0	0	0	0		193.02
193.03	19303	HEALTH EDUCATION	0	53	0	0		193.03

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.04	19304	RENTED SPACE	0	0	0	0		193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0		193.05
200.00		Cross Foot Adjustments					1,039,759	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	489,799	216,383	1,324,552	432,133	1,039,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	56,270					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		81,161				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				48,000		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					13,105	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM						23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
40.00	04000	SUBPROVIDER - IPF						40.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
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
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						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
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
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								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.00	19300	NONPAID WORKERS						193.00
193.01	19301	DENMAN SERVICES						193.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.02	19302	UNUSED SPACE						193.02
193.03	19303	HEALTH EDUCATION						193.03
193.04	19304	RENTED SPACE						193.04
193.05	19305	AUGUSTA PHARMACY						193.05
200.00		Cross Foot Adjustments	56,270	81,161	0	48,000	13,105	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,270	81,161	0	48,000	13,105	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	16,940					23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY		13,081				23.04
23.05	02305	PARAMED ED PRGM-HIM			21,847			23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				5,639,065	0	30.00
31.00	03100	INTENSIVE CARE UNIT				765,408	0	31.00
40.00	04000	SUBPROVIDER - IPF				1,069,504	0	40.00
41.00	04100	SUBPROVIDER - IRF				314,575	0	41.00
43.00	04300	NURSERY				104,007	0	43.00
44.00	04400	SKILLED NURSING FACILITY				408,649	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				5,101,158	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				144,129	0	52.00
53.00	05300	ANESTHESIOLOGY				192,142	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,466,659	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				901,715	0	55.00
57.00	05700	CT SCAN				198,048	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)				94,304	0	58.00
60.00	06000	LABORATORY				987,534	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				79,633	0	62.00
65.00	06500	RESPIRATORY THERAPY				226,864	0	65.00
66.00	06600	PHYSICAL THERAPY				131,532	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				71,152	0	67.00
68.00	06800	SPEECH PATHOLOGY				25,217	0	68.00
69.00	06900	ELECTROCARDIOLOGY				1,065,913	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				166,240	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				685,483	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				854,970	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,205,204	0	73.00
74.00	07400	RENAL DIALYSIS				40,336	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				74,324	0	88.00
90.00	09000	CLINIC				94,606	0	90.00
90.01	09001	OUTPATIENT INFUSION				90,763	0	90.01
91.00	09100	EMERGENCY				912,859	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY				300,896	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE				231,031	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	23,643,920	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				32,183	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				171,110	0	192.00
193.00	19300	NONPAID WORKERS				0	0	193.00
193.01	19301	DENMAN SERVICES				15,439	0	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description			PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATORY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.03	23.04	23.05	24.00	25.00	
193.02	19302	UNUSED SPACE				410,442	0	193.02
193.03	19303	HEALTH EDUCATION				1,314	0	193.03
193.04	19304	RENTED SPACE				466,300	0	193.04
193.05	19305	AUGUSTA PHARMACY				41,778	0	193.05
200.00		Cross Foot Adjustments	16,940	13,081	21,847	1,290,163	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,940	13,081	21,847	26,072,649	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	23.04
23.05	02305	PARAMED ED PRGM-HIM	23.05
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT INFUSION	90.01
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			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	DENMAN SERVICES	193.01
193.02	19302	UNUSED SPACE	193.02
193.03	19303	HEALTH EDUCATION	193.03
193.04	19304	RENTED SPACE	193.04
193.05	19305	AUGUSTA PHARMACY	193.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	1,290,163	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	26,072,649	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	1,092				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	121,466			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	602,402		1.03
1.04	00104	CAP REL COSTS-MOB PHASE I	0	0	0	0	2,472	1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,382	5,502	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	28,133	113,236	2,472	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	19,797	71,587	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,919	1,421	0	8.00
9.00	00900	HOUSEKEEPING	0	0	3,945	1,425	0	9.00
10.00	01000	DIETARY	0	0	0	15,357	0	10.00
11.00	01100	CAFETERIA	0	0	0	6,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,203	820	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	585	3,394	0	16.00
20.00	02000	NURSING SCHOOL	0	0	0	16,051	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	516	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	0	0	0	129	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	0	0	0	387	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	639	127,303	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	9,911	11,236	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	35,882	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,677	4,775	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,575	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	10,435	28,083	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,475	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,524	15,660	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,167	0	55.00
57.00	05700	CT SCAN	0	0	597	1,034	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,989	0	58.00
60.00	06000	LABORATORY	0	0	639	10,209	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,823	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,037	4,755	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,778	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	378	0	6,451	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	525	0	8,974	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	298	4,006	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,499	0	90.01
91.00	09100	EMERGENCY	0	0	5,426	15,114	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								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,092	117,851	548,330	2,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,937	797	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.02	19302	UNUSED SPACE	0	0	127	27,254	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	551	25,021	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	0	36,534	368,924	6,810,454	7,993	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.456044	3.037261	11.305497	3.233414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.05	1.06	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL	59,962					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST	0	16,178				1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			14,022,445			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	122,184	105,568,902		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,528	0	4,850,764	10,710,514	-61,286,455	5.00
6.00	00600	MAINTENANCE & REPAIRS	451	0	337,685	2,857,049	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,127	41,662	0	8.00
9.00	00900	HOUSEKEEPING	31	0	86,926	2,632,018	0	9.00
10.00	01000	DIETARY	0	0	182,266	837,869	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,679,630	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,111	0	729,637	8,398,330	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,513	0	67,983	0	0	16.00
20.00	02000	NURSING SCHOOL	5,725	15,674	154,940	4,457,167	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,116,867	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	750	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,425	0	2,927	293,423	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	2,685	72,304	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	331,890	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	46	126	1,245	140,446	0	23.04
23.05	02305	PARAMED ED PRGM-HIM	138	378	3,734	84,233	0	23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,453,843	17,262,726	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	147,025	3,717,112	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	8,078	4,259,945	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	13,453	1,535,216	0	41.00
43.00	04300	NURSERY	0	0	25,749	262,859	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,006	1,562,709	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	2,383,617	9,386,442	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	29,004	636,514	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	122,893	226,051	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	644,179	3,376,971	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	634,423	1,175,485	0	55.00
57.00	05700	CT SCAN	0	0	127,646	571,596	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	30,282	328,746	0	58.00
60.00	06000	LABORATORY	0	0	248,383	3,399,998	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	15,740	146,573	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,113,546	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	6,985	1,433,984	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,080	854,029	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,641	255,786	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	772,001	2,120,411	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	51,927	434,641	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71,712	325,237	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	99,766	520,634	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	301,339	4,276,966	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,654	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	454,477	0	88.00
90.00	09000	CLINIC	0	0	0	448,395	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	456,034	0	90.01
91.00	09100	EMERGENCY	2,305	0	174,951	4,193,510	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,050	0	641	3,091,140	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	10,108	1,199,402	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,323	16,178	13,936,979	103,680,537	-61,286,455	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	82,226	1,643,565	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.05	1.06	2.00	4.00	5A	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	144	0	0	193.01
193.02	19302	UNUSED SPACE	639	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	26,376	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	3,096	218,424	0	193.05
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)	807,694	61,063	14,025,692	20,154,074		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.470098	3.774447	1.000232	0.190909		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				218,536		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.002070		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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:

2/27/2020 10:31 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	210,730,331				5.00
6.00	00600	MAINTENANCE & REPAIRS	9,964,609	552,692			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,519,557	3,340	1,560,499		8.00
9.00	00900	HOUSEKEEPING	4,203,181	5,401	15,798	112,216	9.00
10.00	01000	DIETARY	1,792,285	15,357	11,492	3,771	10.00
11.00	01100	CAFETERIA	3,211,703	6,051	0	1,486	11.00
13.00	01300	NURSING ADMINISTRATION	11,670,928	9,134	0	2,243	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,084,554	8,492	0	2,085	16.00
20.00	02000	NURSING SCHOOL	3,608,720	37,451	0	9,196	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,330,087	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,099,438	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	311,164	1,941	0	477	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	63,709	516	0	127	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	409,209	0	0	0	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	197,796	301	0	74	23.04
23.05	02305	PARAMED ED PRGM-HIM	182,599	902	0	222	23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,515,918	127,942	522,575	31,419	30.00
31.00	03100	INTENSIVE CARE UNIT	5,042,265	21,147	87,458	5,193	31.00
40.00	04000	SUBPROVIDER - IPF	5,676,523	35,882	19,357	8,811	40.00
41.00	04100	SUBPROVIDER - IRF	2,251,282	9,452	84,856	2,321	41.00
43.00	04300	NURSERY	455,926	3,567	9,461	876	43.00
44.00	04400	SKILLED NURSING FACILITY	2,218,048	11,575	62,211	2,842	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,235,435	38,518	123,980	9,459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	967,716	8,475	43,101	2,081	52.00
53.00	05300	ANESTHESIOLOGY	738,676	1,306	0	321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,478,794	17,184	113,215	4,220	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,421,233	11,167	60,874	2,742	55.00
57.00	05700	CT SCAN	1,207,740	1,631	38,485	401	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	848,409	1,989	9,119	488	58.00
60.00	06000	LABORATORY	8,431,368	10,848	153	2,664	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,497,757	385	0	95	62.00
65.00	06500	RESPIRATORY THERAPY	2,789,095	1,823	0	448	65.00
66.00	06600	PHYSICAL THERAPY	1,778,973	3,398	0	834	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,046,926	1,642	0	403	67.00
68.00	06800	SPEECH PATHOLOGY	320,149	556	0	137	68.00
69.00	06900	ELECTROCARDIOLOGY	4,105,269	12,792	61,984	3,141	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	701,526	1,778	472	437	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,359,784	6,828	8,607	1,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,610,007	9,500	11,973	2,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,556,284	4,304	0	1,057	73.00
74.00	07400	RENAL DIALYSIS	853,236	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	921,796	0	0	0	88.00
90.00	09000	CLINIC	618,561	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	659,274	3,499	513	859	90.01
91.00	09100	EMERGENCY	6,999,864	22,845	269,702	5,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,863,185	2,050	0	503	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,017,778	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,838,336	460,969	1,555,386	111,053	224,073
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,930	3,734	5,113	917	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,231,356	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	11,449	1,000	0	246	193.01
193.02	19302	UNUSED SPACE	317,113	28,020	0	0	193.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	6.00	8.00	9.00	10.00	
193.03	19303	HEALTH EDUCATION	31,490	0	0	0	0	193.03
193.04	19304	RENTED SPACE	284,549	58,969	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	998,108	0	0	0	0	193.05
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)	61,286,455	12,862,606	2,039,219	5,571,928	2,873,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.290829	23.272647	1.306774	49.653597	12.822571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,071,224	1,601,321	93,986	298,489	489,799	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.038301	2.897312	0.060228	2.659950	2.185890	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: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
		11.00	13.00	16.00	20.00	21.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES					1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES					1.03
1.04	00104	CAP REL COSTS-MOB PHASE I					1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL					1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST					1.06
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	421,905				11.00
13.00	01300	NURSING ADMINISTRATION	39,991	1,775,861			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	179,349		16.00
20.00	02000	NURSING SCHOOL	18,788	0	0	31,753	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	5,876	0	0	21,096	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,219	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	316	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	1,131	0	0		23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	675	0	0		23.04
23.05	02305	PARAMED ED PRGM-HIM	154	0	0		23.05
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	103,719	692,218	107,464	23,113	30.00
31.00	03100	INTENSIVE CARE UNIT	18,045	120,429	12,347	1,935	31.00
40.00	04000	SUBPROVIDER - IPF	25,474	170,010	31,250	2,255	40.00
41.00	04100	SUBPROVIDER - IRF	7,770	51,858	11,732	205	41.00
43.00	04300	NURSERY	1,099	7,332	270	502	43.00
44.00	04400	SKILLED NURSING FACILITY	9,447	63,050	15,610	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,210	315,071	0	1,107	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,335	22,255	0	1,468	52.00
53.00	05300	ANESTHESIOLOGY	1,564	10,436	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,700	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,706	0	0	0	55.00
57.00	05700	CT SCAN	2,567	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,447	0	0	0	58.00
60.00	06000	LABORATORY	22,901	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	972	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	11,035	0	0	8	65.00
66.00	06600	PHYSICAL THERAPY	5,775	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,534	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,019	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,340	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,580	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,074	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,711	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,283	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	1,886	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	2,287	15,261	0	28	90.01
91.00	09100	EMERGENCY	26,172	174,666	676	909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,863	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	94,681	0	88	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	38,594	0	135	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	421,802	1,775,861	179,349	31,753	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
			11.00	13.00	16.00	20.00	21.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	103	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	4,360,367	15,802,422	8,155,278	6,180,611	1,777,643	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.334950	8.898457	45.471555	194.646522	84.264458	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	216,383	1,324,552	432,133	1,039,759	56,270	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.512871	0.745865	2.409453	32.745221	2.667330	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATOR Y (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
			22.00					
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-MOB PHASE I						1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL						1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST						1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	21,096					22.00
23.00	02300	PARAMED ED PRGM		0				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			100			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				100		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY					100	23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY						23.04
23.05	02305	PARAMED ED PRGM-HIM						23.05
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,561	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	539	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	637	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	441	0	0	0	0	41.00
43.00	04300	NURSERY	588	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	801	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	163	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49	0	100	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	65	0	0	100	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	752	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	637	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,863	0	0	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								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,096	0	100	100	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATOR Y (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
			22.00	23.00	23.01	23.02	23.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	UNUSED SPACE	0	0	0	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	0	0	0	193.03
193.04	19304	RENTED SPACE	0	0	0	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	0	0	0	193.05
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)	2,710,015	0	483,115	103,818	539,908	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	128.461083	0.000000	4,831.150000	1,038.180000	5,399.080000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	81,161	0	48,000	13,105	16,940	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.847222	0.000000	480.000000	131.050000	169.400000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	0	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	0.000000	0.000000	0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.04	23.05	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES			1.03
1.04	00104	CAP REL COSTS-MOB PHASE I			1.04
1.05	00105	CAP REL COSTS-OAK STREET MALL			1.05
1.06	00106	CAP REL COSTS-BRCN AT 36TH ST			1.06
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY			23.03
23.04	02304	PARAMED ED PRGM-RESPIRATORY	100		23.04
23.05	02305	PARAMED ED PRGM-HIM		179,349	23.05
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	107,464	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,347	31.00
40.00	04000	SUBPROVIDER - IPF	0	31,250	40.00
41.00	04100	SUBPROVIDER - IRF	0	11,732	41.00
43.00	04300	NURSERY	0	270	43.00
44.00	04400	SKILLED NURSING FACILITY	0	15,610	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	676	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					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	179,349	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description			PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)	
			23.04	23.05	
193.02	19302	UNUSED SPACE	0	0	193.02
193.03	19303	HEALTH EDUCATION	0	0	193.03
193.04	19304	RENTED SPACE	0	0	193.04
193.05	19305	AUGUSTA PHARMACY	0	0	193.05
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)	272,976	269,311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,729.760000	1.501603	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,081	21,847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	130.810000	0.121813	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,957,071		57,957,071	14,204	57,971,275	30.00
31.00	03100	INTENSIVE CARE UNIT	9,786,584		9,786,584	0	9,786,584	31.00
40.00	04000	SUBPROVIDER - IPF	12,811,508		12,811,508	4,920	12,816,428	40.00
41.00	04100	SUBPROVIDER - IRF	4,673,819		4,673,819	6,715	4,680,534	41.00
43.00	04300	NURSERY	914,393		914,393	0	914,393	43.00
44.00	04400	SKILLED NURSING FACILITY	4,998,259		4,998,259	628	4,998,887	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,864,793		29,864,793	38,262	29,903,055	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,124,287		2,124,287	0	2,124,287	52.00
53.00	05300	ANESTHESIOLOGY	1,108,865		1,108,865	0	1,108,865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,776,125		9,776,125	0	9,776,125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,649,619		3,649,619	0	3,649,619	55.00
57.00	05700	CT SCAN	1,693,676		1,693,676	0	1,693,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,192,542		1,192,542	0	1,192,542	58.00
60.00	06000	LABORATORY	11,608,892		11,608,892	0	11,608,892	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,957,071		1,957,071	0	1,957,071	62.00
65.00	06500	RESPIRATORY THERAPY	4,053,495	0	4,053,495	5,965	4,059,460	65.00
66.00	06600	PHYSICAL THERAPY	2,476,525	0	2,476,525	0	2,476,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,446,150	0	1,446,150	0	1,446,150	67.00
68.00	06800	SPEECH PATHOLOGY	443,532	0	443,532	0	443,532	68.00
69.00	06900	ELECTROCARDIOLOGY	5,930,393		5,930,393	9,434	5,939,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	995,909		995,909	3,237	999,146	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,239,560		16,239,560	0	16,239,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,260,287		19,260,287	0	19,260,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,675,983		28,675,983	0	28,675,983	73.00
74.00	07400	RENAL DIALYSIS	1,101,382		1,101,382	0	1,101,382	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,189,881		1,189,881	0	1,189,881	88.00
90.00	09000	CLINIC	817,948		817,948	0	817,948	90.00
90.01	09001	OUTPATIENT INFUSION	1,140,648		1,140,648	0	1,140,648	90.01
91.00	09100	EMERGENCY	12,231,720		12,231,720	92,237	12,323,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,899,201		7,899,201		7,899,201	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,209,869		7,209,869		7,209,869	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,974,310		2,974,310		2,974,310	116.00
200.00		Subtotal (see instructions)	268,204,297	0	268,204,297	175,602	268,379,899	200.00
201.00		Less Observation Beds	7,899,201		7,899,201		7,899,201	201.00
202.00		Total (see instructions)	260,305,096	0	260,305,096	175,602	260,480,698	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
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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	94,510,161		94,510,161			30.00	
31.00	03100	INTENSIVE CARE UNIT	39,317,282		39,317,282			31.00	
40.00	04000	SUBPROVIDER - IPF	28,013,248		28,013,248			40.00	
41.00	04100	SUBPROVIDER - IRF	5,983,644		5,983,644			41.00	
43.00	04300	NURSERY	3,606,548		3,606,548			43.00	
44.00	04400	SKILLED NURSING FACILITY	6,252,330		6,252,330			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,180,842	102,662,484	145,843,326	0.204773	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,098,479	1,490,050	9,588,529	0.221545	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	14,050,765	23,617,487	37,668,252	0.029438	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,720,357	45,789,917	62,510,274	0.156392	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,064,034	17,816,284	18,880,318	0.193303	0.000000	55.00	
57.00	05700	CT SCAN	32,812,486	58,479,861	91,292,347	0.018552	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,001,600	16,399,968	24,401,568	0.048872	0.000000	58.00	
60.00	06000	LABORATORY	63,309,258	77,024,848	140,334,106	0.082723	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,576,754	2,765,022	8,341,776	0.234611	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	20,833,733	5,082,893	25,916,626	0.156405	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	4,715,581	614,525	5,330,106	0.464630	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,755,444	205,842	3,961,286	0.365071	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,269,366	317,636	1,587,002	0.279478	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	42,295,459	60,752,833	103,048,292	0.057550	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	431,135	3,052,842	3,483,977	0.285854	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,422,671	60,056,278	105,478,949	0.153960	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,445,356	42,538,230	72,983,586	0.263899	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	89,591,896	98,441,612	188,033,508	0.152505	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	2,866,889	0	2,866,889	0.384173	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,558,541	1,558,541			88.00	
90.00	09000	CLINIC	1,035	830,213	831,248	0.984000	0.000000	90.00	
90.01	09001	OUTPATIENT INFUSION	39,325	3,083,534	3,122,859	0.365258	0.000000	90.01	
91.00	09100	EMERGENCY	17,302,151	35,289,886	52,592,037	0.232577	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,761,519	23,956,477	27,717,996	0.284985	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	6,907,889	6,907,889			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	62,934	3,711,030	3,773,964			116.00	
200.00		Subtotal (see instructions)	633,292,282	692,446,182	1,325,738,464			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	633,292,282	692,446,182	1,325,738,464			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.205035			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.221545			52.00
53.00	05300	ANESTHESIOLOGY	0.029438			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156392			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193303			55.00
57.00	05700	CT SCAN	0.018552			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048872			58.00
60.00	06000	LABORATORY	0.082723			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611			62.00
65.00	06500	RESPIRATORY THERAPY	0.156635			65.00
66.00	06600	PHYSICAL THERAPY	0.464630			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365071			67.00
68.00	06800	SPEECH PATHOLOGY	0.279478			68.00
69.00	06900	ELECTROCARDIOLOGY	0.057641			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.286783			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263899			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152505			73.00
74.00	07400	RENAL DIALYSIS	0.384173			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.984000			90.00
90.01	09001	OUTPATIENT INFUSION	0.365258			90.01
91.00	09100	EMERGENCY	0.234331			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.284985			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	57,957,071		57,957,071	14,204	57,971,275	30.00
31.00	03100	INTENSIVE CARE UNIT	9,786,584		9,786,584	0	9,786,584	31.00
40.00	04000	SUBPROVIDER - IPF	12,811,508		12,811,508	4,920	12,816,428	40.00
41.00	04100	SUBPROVIDER - IRF	4,673,819		4,673,819	6,715	4,680,534	41.00
43.00	04300	NURSERY	914,393		914,393	0	914,393	43.00
44.00	04400	SKILLED NURSING FACILITY	4,998,259		4,998,259	628	4,998,887	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,864,793		29,864,793	38,262	29,903,055	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,124,287		2,124,287	0	2,124,287	52.00
53.00	05300	ANESTHESIOLOGY	1,108,865		1,108,865	0	1,108,865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,776,125		9,776,125	0	9,776,125	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,649,619		3,649,619	0	3,649,619	55.00
57.00	05700	CT SCAN	1,693,676		1,693,676	0	1,693,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,192,542		1,192,542	0	1,192,542	58.00
60.00	06000	LABORATORY	11,608,892		11,608,892	0	11,608,892	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,957,071		1,957,071	0	1,957,071	62.00
65.00	06500	RESPIRATORY THERAPY	4,053,495	0	4,053,495	5,965	4,059,460	65.00
66.00	06600	PHYSICAL THERAPY	2,476,525	0	2,476,525	0	2,476,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,446,150	0	1,446,150	0	1,446,150	67.00
68.00	06800	SPEECH PATHOLOGY	443,532	0	443,532	0	443,532	68.00
69.00	06900	ELECTROCARDIOLOGY	5,930,393		5,930,393	9,434	5,939,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	995,909		995,909	3,237	999,146	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,239,560		16,239,560	0	16,239,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,260,287		19,260,287	0	19,260,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,675,983		28,675,983	0	28,675,983	73.00
74.00	07400	RENAL DIALYSIS	1,101,382		1,101,382	0	1,101,382	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,189,881		1,189,881	0	1,189,881	88.00
90.00	09000	CLINIC	817,948		817,948	0	817,948	90.00
90.01	09001	OUTPATIENT INFUSION	1,140,648		1,140,648	0	1,140,648	90.01
91.00	09100	EMERGENCY	12,231,720		12,231,720	92,237	12,323,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,899,201		7,899,201		7,899,201	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,209,869		7,209,869		7,209,869	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,974,310		2,974,310		2,974,310	116.00
200.00		Subtotal (see instructions)	268,204,297	0	268,204,297	175,602	268,379,899	200.00
201.00		Less Observation Beds	7,899,201		7,899,201		7,899,201	201.00
202.00		Total (see instructions)	260,305,096	0	260,305,096	175,602	260,480,698	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
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			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,510,161		94,510,161			30.00	
31.00	03100	INTENSIVE CARE UNIT	39,317,282		39,317,282			31.00	
40.00	04000	SUBPROVIDER - IPF	28,013,248		28,013,248			40.00	
41.00	04100	SUBPROVIDER - IRF	5,983,644		5,983,644			41.00	
43.00	04300	NURSERY	3,606,548		3,606,548			43.00	
44.00	04400	SKILLED NURSING FACILITY	6,252,330		6,252,330			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,180,842	102,662,484	145,843,326	0.204773	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,098,479	1,490,050	9,588,529	0.221545	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	14,050,765	23,617,487	37,668,252	0.029438	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,720,357	45,789,917	62,510,274	0.156392	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,064,034	17,816,284	18,880,318	0.193303	0.000000	55.00	
57.00	05700	CT SCAN	32,812,486	58,479,861	91,292,347	0.018552	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,001,600	16,399,968	24,401,568	0.048872	0.000000	58.00	
60.00	06000	LABORATORY	63,309,258	77,024,848	140,334,106	0.082723	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,576,754	2,765,022	8,341,776	0.234611	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	20,833,733	5,082,893	25,916,626	0.156405	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	4,715,581	614,525	5,330,106	0.464630	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,755,444	205,842	3,961,286	0.365071	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,269,366	317,636	1,587,002	0.279478	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	42,295,459	60,752,833	103,048,292	0.057550	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	431,135	3,052,842	3,483,977	0.285854	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,422,671	60,056,278	105,478,949	0.153960	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,445,356	42,538,230	72,983,586	0.263899	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	89,591,896	98,441,612	188,033,508	0.152505	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	2,866,889	0	2,866,889	0.384173	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,558,541	1,558,541	0.763458	0.000000	88.00	
90.00	09000	CLINIC	1,035	830,213	831,248	0.984000	0.000000	90.00	
90.01	09001	OUTPATIENT INFUSION	39,325	3,083,534	3,122,859	0.365258	0.000000	90.01	
91.00	09100	EMERGENCY	17,302,151	35,289,886	52,592,037	0.232577	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,761,519	23,956,477	27,717,996	0.284985	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	6,907,889	6,907,889			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	62,934	3,711,030	3,773,964			116.00	
200.00		Subtotal (see instructions)	633,292,282	692,446,182	1,325,738,464			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	633,292,282	692,446,182	1,325,738,464			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	OUTPATIENT INFUSION	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,639,065	0	5,639,065	45,912	122.82	30.00
31.00	INTENSIVE CARE UNIT	765,408		765,408	4,634	165.17	31.00
40.00	SUBPROVIDER - IPF	1,069,504	0	1,069,504	11,621	92.03	40.00
41.00	SUBPROVIDER - IRF	314,575	0	314,575	4,307	73.04	41.00
43.00	NURSERY	104,007		104,007	2,293	45.36	43.00
44.00	SKILLED NURSING FACILITY	408,649		408,649	5,857	69.77	44.00
200.00	Total (lines 30 through 199)	8,301,208		8,301,208	74,624		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	22,778	2,797,594				
31.00	INTENSIVE CARE UNIT	2,359	389,636				
40.00	SUBPROVIDER - IPF	1,492	137,309				
41.00	SUBPROVIDER - IRF	2,767	202,102				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,091	285,429				
200.00	Total (lines 30 through 199)	33,487	3,812,070				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 10:31 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,101,158	145,843,326	0.034977	22,550,643	788,754	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,129	9,588,529	0.015031	41,656	626	52.00
53.00	05300	ANESTHESIOLOGY	192,142	37,668,252	0.005101	6,866,564	35,026	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,466,659	62,510,274	0.023463	8,918,593	209,257	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	901,715	18,880,318	0.047760	688,697	32,892	55.00
57.00	05700	CT SCAN	198,048	91,292,347	0.002169	17,031,791	36,942	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,304	24,401,568	0.003865	4,036,418	15,601	58.00
60.00	06000	LABORATORY	987,534	140,334,106	0.007037	32,034,444	225,426	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,633	8,341,776	0.009546	3,187,529	30,428	62.00
65.00	06500	RESPIRATORY THERAPY	226,864	25,916,626	0.008754	12,071,273	105,672	65.00
66.00	06600	PHYSICAL THERAPY	131,532	5,330,106	0.024677	1,447,110	35,710	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,152	3,961,286	0.017962	916,481	16,462	67.00
68.00	06800	SPEECH PATHOLOGY	25,217	1,587,002	0.015890	462,684	7,352	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,913	103,048,292	0.010344	23,858,089	246,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166,240	3,483,977	0.047716	237,006	11,309	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	685,483	105,478,949	0.006499	23,279,968	151,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	854,970	72,983,586	0.011715	17,715,300	207,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,205,204	188,033,508	0.006410	41,136,215	263,683	73.00
74.00	07400	RENAL DIALYSIS	40,336	2,866,889	0.014070	1,109,009	15,604	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	74,324	1,558,541	0.047688	0	0	88.00
90.00	09000	CLINIC	94,606	831,248	0.113812	1,035	118	90.00
90.01	09001	OUTPATIENT INFUSION	90,763	3,122,859	0.029064	31,210	907	90.01
91.00	09100	EMERGENCY	912,859	52,592,037	0.017357	8,341,238	144,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	768,379	27,717,996	0.027721	1,648,507	45,698	92.00
200.00		Total (lines 50 through 199)	15,579,164	1,137,373,398		227,611,460	2,627,866	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/27/2020 10:31 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description				Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
				1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	4,498,864	0	161,369	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	376,641	0	18,540	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	438,928	0	46,925	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	39,903	0	17,617	0	41.00		
43.00	04300	NURSERY	0	97,713	0	405	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	23,440	0	44.00		
200.00		Total (lines 30 through 199)	0	5,452,049	0	268,296	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	4,660,233	45,912	101.50	22,778	30.00		
31.00	03100	INTENSIVE CARE UNIT		395,181	4,634	85.28	2,359	31.00		
40.00	04000	SUBPROVIDER - IPF	0	485,853	11,621	41.81	1,492	40.00		
41.00	04100	SUBPROVIDER - IRF	0	57,520	4,307	13.36	2,767	41.00		
43.00	04300	NURSERY		98,118	2,293	42.79	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		23,440	5,857	4.00	4,091	44.00		
200.00		Total (lines 30 through 199)		5,720,345	74,624		33,487	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	2,311,967							30.00
31.00	03100	INTENSIVE CARE UNIT	201,176							31.00
40.00	04000	SUBPROVIDER - IPF	62,381							40.00
41.00	04100	SUBPROVIDER - IRF	36,967							41.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	16,364							44.00
200.00		Total (lines 30 through 199)	2,628,855							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	215,474	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	285,741	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	483,115	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	103,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,557	272,976	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	539,908	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	5,450	0	90.01
91.00	09100	EMERGENCY	0	0	176,934	1,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	613,017	21,991	92.00
200.00		Total (lines 50 through 199)	0	0	1,298,173	1,422,823	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:31 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	215,474	215,474	145,843,326	0.001477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	285,741	285,741	9,588,529	0.029800	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	37,668,252	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	483,115	483,115	62,510,274	0.007729	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,880,318	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	91,292,347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,401,568	0.000000	58.00
60.00	06000	LABORATORY	0	103,818	103,818	140,334,106	0.000740	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8,341,776	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	274,533	274,533	25,916,626	0.010593	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,330,106	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,961,286	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,587,002	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	103,048,292	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,483,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	105,478,949	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,983,586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	539,908	539,908	188,033,508	0.002871	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,866,889	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,558,541	0.000000	88.00
90.00	09000	CLINIC	0	0	0	831,248	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	5,450	5,450	3,122,859	0.001745	90.01
91.00	09100	EMERGENCY	0	177,949	177,949	52,592,037	0.003384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	635,008	635,008	27,717,996	0.022910	92.00
200.00		Total (lines 50 through 199)	0	2,720,996	2,720,996	1,137,373,398		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:31 pm

				Title XVIII		Hospital	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	0.001477	22,550,643	33,307	36,241,526	53,529	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.029800	41,656	1,241	14,788	441	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,866,564	0	7,608,587	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007729	8,918,593	68,932	13,420,614	103,728	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	688,697	0	14,549,924	0	55.00
57.00	05700	CT SCAN	0.000000	17,031,791	0	18,262,254	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,036,418	0	5,221,087	0	58.00
60.00	06000	LABORATORY	0.000740	32,034,444	23,705	10,671,890	7,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,187,529	0	1,192,361	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.010593	12,071,273	127,871	2,406,511	25,492	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,447,110	0	61,893	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	916,481	0	41,665	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	462,684	0	7,864	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,858,089	0	29,025,305	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	237,006	0	1,014,852	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23,279,968	0	22,677,611	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,715,300	0	19,294,383	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002871	41,136,215	118,102	32,534,549	93,407	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,109,009	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	1,035	0	410,771	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.001745	31,210	54	1,388,919	2,424	90.01
91.00	09100	EMERGENCY	0.003384	8,341,238	28,227	7,678,345	25,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.022910	1,648,507	37,767	8,718,048	199,730	92.00
200.00		Total (lines 50 through 199)		227,611,460	439,206	232,443,747	512,632	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.204773	36,241,526	0	0	7,421,286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.221545	14,788	0	0	3,276	52.00
53.00	05300	ANESTHESIOLOGY	0.029438	7,608,587	0	0	223,982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156392	13,420,614	0	0	2,098,877	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193303	14,549,924	0	0	2,812,544	55.00
57.00	05700	CT SCAN	0.018552	18,262,254	0	0	338,801	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048872	5,221,087	0	0	255,165	58.00
60.00	06000	LABORATORY	0.082723	10,671,890	0	0	882,811	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	1,192,361	0	0	279,741	62.00
65.00	06500	RESPIRATORY THERAPY	0.156405	2,406,511	0	0	376,390	65.00
66.00	06600	PHYSICAL THERAPY	0.464630	61,893	0	0	28,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365071	41,665	0	0	15,211	67.00
68.00	06800	SPEECH PATHOLOGY	0.279478	7,864	0	0	2,198	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057550	29,025,305	0	0	1,670,406	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.285854	1,014,852	0	0	290,100	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	22,677,611	0	0	3,491,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263899	19,294,383	166,995	0	5,091,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152505	32,534,549	0	0	4,961,681	73.00
74.00	07400	RENAL DIALYSIS	0.384173	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.984000	410,771	0	0	404,199	90.00
90.01	09001	OUTPATIENT INFUSION	0.365258	1,388,919	0	0	507,314	90.01
91.00	09100	EMERGENCY	0.232577	7,678,345	0	0	1,785,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	8,718,048	0	0	2,484,513	92.00
200.00		Subtotal (see instructions)		232,443,747	166,995	0	35,426,271	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		232,443,747	166,995	0	35,426,271	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,070	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	44,070	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	44,070	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,101,158	145,843,326	0.034977	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,129	9,588,529	0.015031	0	0 52.00
53.00	05300	ANESTHESIOLOGY	192,142	37,668,252	0.005101	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,466,659	62,510,274	0.023463	36,754	862 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	901,715	18,880,318	0.047760	0	0 55.00
57.00	05700	CT SCAN	198,048	91,292,347	0.002169	67,550	147 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,304	24,401,568	0.003865	6,725	26 58.00
60.00	06000	LABORATORY	987,534	140,334,106	0.007037	438,311	3,084 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,633	8,341,776	0.009546	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	226,864	25,916,626	0.008754	29,823	261 65.00
66.00	06600	PHYSICAL THERAPY	131,532	5,330,106	0.024677	1,418	35 66.00
67.00	06700	OCCUPATIONAL THERAPY	71,152	3,961,286	0.017962	988	18 67.00
68.00	06800	SPEECH PATHOLOGY	25,217	1,587,002	0.015890	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,913	103,048,292	0.010344	86,169	891 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166,240	3,483,977	0.047716	4,246	203 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	685,483	105,478,949	0.006499	11,311	74 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	854,970	72,983,586	0.011715	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,205,204	188,033,508	0.006410	588,785	3,774 73.00
74.00	07400	RENAL DIALYSIS	40,336	2,866,889	0.014070	0	0 74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	74,324	1,558,541	0.047688	0	0 88.00
90.00	09000	CLINIC	94,606	831,248	0.113812	0	0 90.00
90.01	09001	OUTPATIENT INFUSION	90,763	3,122,859	0.029064	0	0 90.01
91.00	09100	EMERGENCY	912,859	52,592,037	0.017357	199,217	3,458 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,717,996	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	14,810,785	1,137,373,398		1,471,297	12,833 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	215,474	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	285,741	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	483,115	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	103,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	1,557	0	272,976	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	539,908	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0	0	5,450	0	0	90.01
91.00	09100	EMERGENCY		0	0	176,934	0	1,015	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	685,156	0	1,400,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		215,474	215,474	145,843,326	0.001477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		285,741	285,741	9,588,529	0.029800	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	37,668,252	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		483,115	483,115	62,510,274	0.007729	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	18,880,318	0.000000	55.00
57.00	05700	CT SCAN	0		0	0	91,292,347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	24,401,568	0.000000	58.00
60.00	06000	LABORATORY	0		103,818	103,818	140,334,106	0.000740	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	8,341,776	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0		274,533	274,533	25,916,626	0.010593	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	5,330,106	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	3,961,286	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	1,587,002	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	103,048,292	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	3,483,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	105,478,949	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	72,983,586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		539,908	539,908	188,033,508	0.002871	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	2,866,889	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	1,558,541	0.000000	88.00
90.00	09000	CLINIC	0		0	0	831,248	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0		5,450	5,450	3,122,859	0.001745	90.01
91.00	09100	EMERGENCY	0		177,949	177,949	52,592,037	0.003384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	27,717,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0		2,085,988	2,085,988	1,137,373,398		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.001477	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.029800	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.007729	36,754	284	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	67,550	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	6,725	0	0	0	58.00
60.00	06000	LABORATORY		0.000740	438,311	324	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.010593	29,823	316	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,418	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	988	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	86,169	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	4,246	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	11,311	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		0.002871	588,785	1,690	680	2	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0.001745	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.003384	199,217	674	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)			1,471,297	3,288	680	2	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IPF		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	0.204773	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.221545	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029438	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156392	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193303	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.018552	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048872	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.082723	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.156405	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.464630	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365071	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.279478	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057550	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.285854	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263899	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152505	680	0	2,636	104	73.00	
74.00	07400	RENAL DIALYSIS	0.384173	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.984000	0	0	0	0	90.00	
90.01	09001	OUTPATIENT INFUSION	0.365258	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.232577	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		680	0	2,636	104	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		680	0	2,636	104	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/27/2020 10:31 pm		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	402					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	OUTPATIENT INFUSION	0	0					90.01
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	402					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	402					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/27/2020 10:31 pm		
				Component CCN: 14-T015				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,101,158	145,843,326	0.034977	36,999	1,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,129	9,588,529	0.015031	0	0	52.00
53.00	05300	ANESTHESIOLOGY	192,142	37,668,252	0.005101	4,251	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,466,659	62,510,274	0.023463	123,448	2,896	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	901,715	18,880,318	0.047760	53,383	2,550	55.00
57.00	05700	CT SCAN	198,048	91,292,347	0.002169	118,066	256	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,304	24,401,568	0.003865	38,115	147	58.00
60.00	06000	LABORATORY	987,534	140,334,106	0.007037	804,481	5,661	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,633	8,341,776	0.009546	46,929	448	62.00
65.00	06500	RESPIRATORY THERAPY	226,864	25,916,626	0.008754	188,508	1,650	65.00
66.00	06600	PHYSICAL THERAPY	131,532	5,330,106	0.024677	981,312	24,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,152	3,961,286	0.017962	913,020	16,400	67.00
68.00	06800	SPEECH PATHOLOGY	25,217	1,587,002	0.015890	369,650	5,874	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,913	103,048,292	0.010344	46,151	477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166,240	3,483,977	0.047716	5,017	239	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	685,483	105,478,949	0.006499	91,118	592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	854,970	72,983,586	0.011715	14,505	170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,205,204	188,033,508	0.006410	847,818	5,435	73.00
74.00	07400	RENAL DIALYSIS	40,336	2,866,889	0.014070	105,081	1,478	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	74,324	1,558,541	0.047688	0	0	88.00
90.00	09000	CLINIC	94,606	831,248	0.113812	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	90,763	3,122,859	0.029064	0	0	90.01
91.00	09100	EMERGENCY	912,859	52,592,037	0.017357	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,717,996	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	14,810,785	1,137,373,398		4,787,852	69,805	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0015
Component CCN: 14-T015

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:31 pm

			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	215,474	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	285,741	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	483,115	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	103,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,557	0	272,976	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	539,908	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	5,450	0	0	90.01
91.00	09100	EMERGENCY	0	0	176,934	0	1,015	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	685,156	0	1,400,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		215,474	215,474	145,843,326	0.001477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		285,741	285,741	9,588,529	0.029800	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	37,668,252	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		483,115	483,115	62,510,274	0.007729	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	18,880,318	0.000000	55.00
57.00	05700	CT SCAN	0		0	0	91,292,347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	24,401,568	0.000000	58.00
60.00	06000	LABORATORY	0		103,818	103,818	140,334,106	0.000740	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	8,341,776	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0		274,533	274,533	25,916,626	0.010593	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	5,330,106	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	3,961,286	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	1,587,002	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	103,048,292	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	3,483,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	105,478,949	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	72,983,586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		539,908	539,908	188,033,508	0.002871	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	2,866,889	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	1,558,541	0.000000	88.00
90.00	09000	CLINIC	0		0	0	831,248	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0		5,450	5,450	3,122,859	0.001745	90.01
91.00	09100	EMERGENCY	0		177,949	177,949	52,592,037	0.003384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	27,717,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0		2,085,988	2,085,988	1,137,373,398		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.001477	36,999	55	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.029800	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	4,251	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.007729	123,448	954	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	53,383	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	118,066	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	38,115	0	0	0	58.00
60.00	06000	LABORATORY		0.000740	804,481	595	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	46,929	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.010593	188,508	1,997	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	981,312	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	913,020	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	369,650	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	46,151	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	5,017	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	91,118	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	14,505	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.002871	847,818	2,434	40	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	105,081	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0.001745	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.003384	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)			4,787,852	6,035	40	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.204773	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.221545	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029438	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156392	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193303	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.018552	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048872	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.082723	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.156405	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.464630	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365071	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.279478	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057550	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.285854	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263899	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152505	40	0	479	6	73.00	
74.00	07400	RENAL DIALYSIS	0.384173	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
90.00	09000	CLINIC	0.984000	0	0	0	0	90.00	
90.01	09001	OUTPATIENT INFUSION	0.365258	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.232577	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		40	0	479	6	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		40	0	479	6	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0015 Component CCN: 14-T015		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/27/2020 10:31 pm
			Title XVIII		Subprovider - IRF	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
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	73		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	73		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				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	215,474	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	285,741	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	483,115	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	103,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	1,557	0	272,976	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	539,908	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION		0	0	5,450	0	0	90.01
91.00	09100	EMERGENCY		0	0	176,934	0	1,015	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	685,156	0	1,400,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		215,474	215,474	145,843,326	0.001477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		285,741	285,741	9,588,529	0.029800	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	37,668,252	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		483,115	483,115	62,510,274	0.007729	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	18,880,318	0.000000	55.00
57.00	05700	CT SCAN	0		0	0	91,292,347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	24,401,568	0.000000	58.00
60.00	06000	LABORATORY	0		103,818	103,818	140,334,106	0.000740	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	8,341,776	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0		274,533	274,533	25,916,626	0.010593	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	5,330,106	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	3,961,286	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	1,587,002	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	103,048,292	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	3,483,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	105,478,949	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	72,983,586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		539,908	539,908	188,033,508	0.002871	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	2,866,889	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	1,558,541	0.000000	88.00
90.00	09000	CLINIC	0		0	0	831,248	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0		5,450	5,450	3,122,859	0.001745	90.01
91.00	09100	EMERGENCY	0		177,949	177,949	52,592,037	0.003384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	27,717,996	0.000000	92.00
200.00		Total (lines 50 through 199)	0		2,085,988	2,085,988	1,137,373,398		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0015 Component CCN: 14-5643		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:31 pm	
				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		0.001477	2,059		0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.029800	0		0		52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0		0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.007729	223,441	1,727	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0		0		55.00
57.00	05700	CT SCAN		0.000000	792	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0		58.00
60.00	06000	LABORATORY		0.000740	1,374,910	1,017	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	51,794	0	0		62.00
65.00	06500	RESPIRATORY THERAPY		0.010593	984,077	10,424	0		65.00
66.00	06600	PHYSICAL THERAPY		0.000000	750,622	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	699,535	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	40,520	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	66,340	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	3,024	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	155,449	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		0.002871	2,324,845	6,675	0		73.00
74.00	07400	RENAL DIALYSIS		0.000000	164,697	0	0		74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0		88.00
90.00	09000	CLINIC		0.000000	0	0	0		90.00
90.01	09001	OUTPATIENT INFUSION		0.001745	365	1	0		90.01
91.00	09100	EMERGENCY		0.003384	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)			6,842,470	19,847	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 10:31 pm

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	0.204773	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.221545	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.029438	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156392	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.193303	0	0	0	0 55.00
57.00	05700 CT SCAN	0.018552	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048872	0	0	0	0 58.00
60.00	06000 LABORATORY	0.082723	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.156405	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.464630	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.365071	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.279478	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.057550	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.285854	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.263899	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152505	0	0	26,594	0 73.00
74.00	07400 RENAL DIALYSIS	0.384173	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
90.00	09000 CLINIC	0.984000	0	0	0	0 90.00
90.01	09001 OUTPATIENT INFUSION	0.365258	0	0	0	0 90.01
91.00	09100 EMERGENCY	0.232577	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	26,594	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	26,594	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015

Period:

Worksheet D

Component CCN: 14-5643

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 10:31 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Costs		
		Cost	Cost	
		Reimbursed	Reimbursed	
		Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)	
		6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,056	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	4,056	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	4,056	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm
		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)		45,912	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,912	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)		39,656	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)		22,778	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)		57,971,275	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)		57,971,275	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)		57,971,275	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,262.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		28,760,869	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)		28,760,869	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,786,584	4,634	2,111.91	2,359	4,981,996
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)					32,139,829
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					65,882,694
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,700,373
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,067,072
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,767,445
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					57,115,249
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)					6,256
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,262.66
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,899,201

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 10:31 pm

		Title XVIII		Hospital	PPS		
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,639,065	57,971,275	0.097273	7,899,201	768,379	90.00
91.00	Nursing School cost	4,498,864	57,971,275	0.077605	7,899,201	613,017	91.00
92.00	Allied health cost	161,369	57,971,275	0.002784	7,899,201	21,991	92.00
93.00	All other Medical Education	0	57,971,275	0.000000	7,899,201	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,621	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)		11,621	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)		1,492	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)		12,816,428	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)		12,816,428	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)		12,816,428	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,102.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,645,482	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)		1,645,482	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:

Worksheet D-1

Component CCN: 14-S015

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)					193,681	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,839,163	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)					199,690	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					16,121	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					215,811	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,623,352	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: 14-0015 Component CCN: 14-S015		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,069,504	12,816,428	0.083448	0	0	90.00
91.00	Nursing School cost	438,928	12,816,428	0.034247	0	0	91.00
92.00	Allied health cost	46,925	12,816,428	0.003661	0	0	92.00
93.00	All other Medical Education	0	12,816,428	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,307	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,307	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)		4,307	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)		2,767	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)		4,680,534	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)		4,680,534	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)		4,680,534	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,086.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,006,982	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,006,982	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015

Period:

Worksheet D-1

Component CCN: 14-T015

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

Title XVIII

Subprovider -

PPS

	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,232,669	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,239,651	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)					239,069	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					75,840	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					314,909	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,924,742	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: 14-0015 Component CCN: 14-T015		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	314,575	4,680,534	0.067209	0	0	90.00
91.00 Nursing School cost	39,903	4,680,534	0.008525	0	0	91.00
92.00 Allied health cost	17,617	4,680,534	0.003764	0	0	92.00
93.00 All other Medical Education	0	4,680,534	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm
		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)		5,857	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,857	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)		5,857	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,091	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)		4,998,887	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)		4,998,887	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)		4,998,887	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: 14-0015 Component CCN: 14-5643	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm
			Title XVIII	Skilled Nursing Facility	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)					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)				4,998,887	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				853.49	71.00
72.00 Program routine service cost (line 9 x line 71)				3,491,628	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)				3,491,628	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)				3,491,628	83.00
84.00 Program inpatient ancillary services (see instructions)				1,377,454	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)				4,869,082	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: 14-0015 Component CCN: 14-5643		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:31 pm	
			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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:31 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		58,382,388	30.00
31.00	03100	INTENSIVE CARE UNIT		19,577,806	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.205035	22,550,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.221545	41,656	52.00
53.00	05300	ANESTHESIOLOGY	0.029438	6,866,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156392	8,918,593	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193303	688,697	55.00
57.00	05700	CT SCAN	0.018552	17,031,791	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048872	4,036,418	58.00
60.00	06000	LABORATORY	0.082723	32,034,444	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	3,187,529	62.00
65.00	06500	RESPIRATORY THERAPY	0.156635	12,071,273	65.00
66.00	06600	PHYSICAL THERAPY	0.464630	1,447,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.365071	916,481	67.00
68.00	06800	SPEECH PATHOLOGY	0.279478	462,684	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057641	23,858,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.286783	237,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	23,279,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263899	17,715,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152505	41,136,215	73.00
74.00	07400	RENAL DIALYSIS	0.384173	1,109,009	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.984000	1,035	90.00
90.01	09001	OUTPATIENT INFUSION	0.365258	31,210	90.01
91.00	09100	EMERGENCY	0.234331	8,341,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	1,648,507	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		227,611,460	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)		227,611,460	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,637,851		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.205035	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.221545	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029438	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156392	36,754	5,748	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.193303	0	0	55.00
57.00	05700 CT SCAN	0.018552	67,550	1,253	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048872	6,725	329	58.00
60.00	06000 LABORATORY	0.082723	438,311	36,258	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.156635	29,823	4,671	65.00
66.00	06600 PHYSICAL THERAPY	0.464630	1,418	659	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.365071	988	361	67.00
68.00	06800 SPEECH PATHOLOGY	0.279478	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.057641	86,169	4,967	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.286783	4,246	1,218	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	11,311	1,741	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.263899	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152505	588,785	89,793	73.00
74.00	07400 RENAL DIALYSIS	0.384173	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.984000	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.365258	0	0	90.01
91.00	09100 EMERGENCY	0.234331	199,217	46,683	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,471,297	193,681	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)		1,471,297		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		3,897,949		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.205035	36,999	7,586	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.221545	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029438	4,251	125	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156392	123,448	19,306	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.193303	53,383	10,319	55.00
57.00	05700 CT SCAN	0.018552	118,066	2,190	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048872	38,115	1,863	58.00
60.00	06000 LABORATORY	0.082723	804,481	66,549	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	46,929	11,010	62.00
65.00	06500 RESPIRATORY THERAPY	0.156635	188,508	29,527	65.00
66.00	06600 PHYSICAL THERAPY	0.464630	981,312	455,947	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.365071	913,020	333,317	67.00
68.00	06800 SPEECH PATHOLOGY	0.279478	369,650	103,309	68.00
69.00	06900 ELECTROCARDIOLOGY	0.057641	46,151	2,660	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.286783	5,017	1,439	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	91,118	14,029	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.263899	14,505	3,828	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152505	847,818	129,296	73.00
74.00	07400 RENAL DIALYSIS	0.384173	105,081	40,369	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.984000	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.365258	0	0	90.01
91.00	09100 EMERGENCY	0.234331	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,787,852	1,232,669	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)		4,787,852		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:31 pm	
		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
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.205035	2,059	422	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.221545	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029438	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156392	223,441	34,944	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.193303	0	0	55.00
57.00	05700 CT SCAN	0.018552	792	15	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048872	0	0	58.00
60.00	06000 LABORATORY	0.082723	1,374,910	113,737	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.234611	51,794	12,151	62.00
65.00	06500 RESPIRATORY THERAPY	0.156635	984,077	154,141	65.00
66.00	06600 PHYSICAL THERAPY	0.464630	750,622	348,761	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.365071	699,535	255,380	67.00
68.00	06800 SPEECH PATHOLOGY	0.279478	40,520	11,324	68.00
69.00	06900 ELECTROCARDIOLOGY	0.057641	66,340	3,824	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.286783	3,024	867	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.153960	155,449	23,933	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.263899	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152505	2,324,845	354,550	73.00
74.00	07400 RENAL DIALYSIS	0.384173	164,697	63,272	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.984000	0	0	90.00
90.01	09001 OUTPATIENT INFUSION	0.365258	365	133	90.01
91.00	09100 EMERGENCY	0.234331	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.284985	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,842,470	1,377,454	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)		6,842,470		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			50,624,696	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			997,282	2.04
3.00	Managed Care Simulated Payments			8,161,892	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			230.86	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)			13.16	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)			13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			17.30	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)			13.16	12.00
13.00	Total allowable FTE count for the prior year.			13.16	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.			13.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.			13.16	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			13.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.057004	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.069409	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.057004	21.00
22.00	IME payment adjustment (see instructions)			1,551,849	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			250,195	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)			4.14	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)			1,551,849	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			250,195	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.78	30.00
31.00	Percentage of Medicaid patient days (see instructions)			17.63	31.00
32.00	Sum of lines 30 and 31			22.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)			7.70	33.00
34.00	Disproportionate share adjustment (see instructions)			974,526	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000460520		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	3,809,823	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	3,809,823	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,809,823		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
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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		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)		57,958,176		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		63,179,845		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			63,430,040	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			4,366,111	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).			578,072	52.00
53.00	Nursing and Allied Health Managed Care payment			508,009	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).			2,513,143	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			439,206	58.00
59.00	Total (sum of amounts on lines 49 through 58)			71,834,581	59.00
60.00	Primary payer payments			22,871	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			71,811,710	61.00
62.00	Deductibles billed to program beneficiaries			5,589,936	62.00
63.00	Coinsurance billed to program beneficiaries			81,396	63.00
64.00	Allowable bad debts (see instructions)			1,469,813	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			955,378	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,359,425	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67,095,756	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 PER PS&R			-154	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)			218,629	70.93
70.94	HRR adjustment amount (see instructions)			-293,622	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		67,020,609	71.00	
71.01	Sequestration adjustment (see instructions)		1,340,412	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		64,850,241	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		829,956	74.00	
75.00	Contested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,309,213	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
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVB 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	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		44,070	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		34,913,639	2.00
3.00	OPPS payments		34,520,524	3.00
4.00	Outlier payment (see instructions)		78,881	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.897	5.00
6.00	Line 2 times line 5		31,317,534	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		512,632	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		44,070	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		166,995	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)		166,995	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)		166,995	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		122,925	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)		44,070	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)		35,112,037	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		33,399	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,277,091	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)		28,845,617	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		267,343	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)		29,112,960	30.00
31.00	Primary payer payments		399	31.00
32.00	Subtotal (line 30 minus line 31)		29,112,561	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)		1,143,833	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		743,491	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,061,381	36.00
37.00	Subtotal (see instructions)		29,856,052	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-1	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		29,856,053	40.00
40.01	Sequestration adjustment (see instructions)		597,121	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		28,875,838	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		383,094	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		402	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		102	2.00
3.00	OPPS payments		578	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		2	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		402	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,636	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)		2,636	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)		2,636	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,234	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)		402	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)		580	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)		0	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)		982	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)		982	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		982	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)		982	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)		982	40.00
40.01	Sequestration adjustment (see instructions)		20	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		911	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		51	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IRF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		73	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6	2.00
3.00	OPPS payments		0	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)		73	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		479	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)		479	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)		479	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		406	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)		73	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)		0	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)		73	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)		73	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		73	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)		73	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)		73	40.00
40.01	Sequestration adjustment (see instructions)		1	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		89	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-17	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		4,056	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)		4,056	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,594	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)		26,594	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)		26,594	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		22,538	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)		4,056	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)		4,056	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)		4,056	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,056	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)		4,056	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)		4,056	40.00
40.01	Sequestration adjustment (see instructions)		81	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		26,062	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-22,087	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 10:31 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		65,414,331		28,855,704	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	05/13/2019	20,134	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	05/13/2019	374,104		0	3.50
3.51		09/25/2019	189,986		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)		-564,090		20,134	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)		64,850,241		28,875,838	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		829,956		383,094	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		65,680,197		29,258,932	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: 14-0015
 Component CCN: 14-S015

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 10:31 pm

Title XVIII

 Subprovider -
 IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,135,763		911	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)		1,135,763		911	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		191,417		51	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,327,180		962	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: 14-0015
 Component CCN: 14-T015

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 10:31 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,182,582		89		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0		3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,182,582		89		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		65,426		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		17		6.02
7.00	Total Medicare program liability (see instructions)		4,248,008		72		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: 14-0015
 Component CCN: 14-5643

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 10:31 pm

		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		1,434,670		26,062		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)		1,434,670		26,062		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		35,970		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		22,087		6.02
7.00	Total Medicare program liability (see instructions)		1,470,640		3,975		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: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,353,433 1.00
2.00	Net IPF PPS Outlier Payments			30,051 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)			31.838356 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)			1,383,484 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,383,484 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,383,484 18.00
19.00	Deductibles			196,916 19.00
20.00	Subtotal (line 18 minus line 19)			1,186,568 20.00
21.00	Coinsurance			27,626 21.00
22.00	Subtotal (line 20 minus line 21)			1,158,942 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			199,468 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			129,654 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			188,916 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,288,596 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			65,669 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)			1,354,265 31.00
31.01	Sequestration adjustment (see instructions)			27,085 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,135,763 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)			191,417 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			30,051 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: 14-0015 Component CCN: 14-T015	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part III Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,050,409 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0164 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			107,741 3.00
4.00	Outlier Payments			168,733 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.800000 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,326,883 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,326,883 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,326,883 19.00
20.00	Deductibles			16,296 20.00
21.00	Subtotal (line 19 minus line 20)			4,310,587 21.00
22.00	Coinsurance			19,742 22.00
23.00	Subtotal (line 21 minus line 22)			4,290,845 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,316 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			855 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,291,700 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			43,002 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,334,702 32.00
32.01	Sequestration adjustment (see instructions)			86,694 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,182,582 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			65,426 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			168,733 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: 14-0015 Component CCN: 14-5643	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 2/27/2020 10:31 pm
		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)			1,535,923 1.00
2.00	Routine service other pass through costs			16,364 2.00
3.00	Ancillary service other pass through costs			19,847 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,572,134 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			71,975 7.00
8.00	Allowable bad debts (see instructions)			760 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			494 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,500,653 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,500,653 15.00
15.01	Sequestration adjustment (see instructions)			30,013 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
16.00	Interim payments			1,434,670 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			35,970 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E-4 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			17.30	6.00
7.00	Enter the lesser of line 5 or line 6			17.30	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.30	0.00	17.30	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.30	0.00	17.30	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	17.30	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.25	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.52	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	17.52	0.00		17.00
18.00	Per resident amount	87,165.03	0.00		18.00
19.00	Approved amount for resident costs	1,527,131	0	1,527,131	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,527,131	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	29,396	4,761		26.00
27.00	Total Inpatient Days (see instructions)	60,485	60,485		27.00
28.00	Ratio of inpatient days to total inpatient days	0.486005	0.078714		28.00
29.00	Program direct GME amount	742,193	120,207		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		16,985		30.00
31.00	Net Program direct GME amount			845,415	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet E-4 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,866,889	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			77,025,270	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			22,871	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			77,002,399	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			35,616,467	42.00
43.00	Primary payer payments (see instructions)			4,947	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			35,611,520	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			112,613,919	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.683773	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.316227	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			845,415	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			578,072	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			267,343	50.00

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

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/27/2020 10:31 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	96,575,824	0	0	0	1.00
2.00	Temporary investments	165,235,745	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	233,395,737	0	0	0	4.00
5.00	Other receivable	12,059,145	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-175,989,146	0	0	0	6.00
7.00	Inventory	7,912,084	0	0	0	7.00
8.00	Prepaid expenses	6,405,329	0	0	0	8.00
9.00	Other current assets	224,150	0	0	0	9.00
10.00	Due from other funds	3,324,388	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	349,143,256	0	0	0	11.00
FIXED ASSETS						
12.00	Land	14,717,941	0	0	0	12.00
13.00	Land improvements	8,120,095	0	0	0	13.00
14.00	Accumulated depreciation	-5,079,663	0	0	0	14.00
15.00	Buildings	258,971,241	0	0	0	15.00
16.00	Accumulated depreciation	-92,661,309	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	184,587,528	0	0	0	23.00
24.00	Accumulated depreciation	-117,471,879	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)	251,183,954	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	40,992,891	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	671,124	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,664,015	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	641,991,225	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	24,446,514	0	0	0	37.00
38.00	Salaries, wages, and fees payable	20,671,993	0	0	0	38.00
39.00	Payroll taxes payable	628,647	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,894,765	0	0	0	40.00
41.00	Deferred income	1,867,127	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	21,892,298	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	71,401,344	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	119,909,236	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	67,945,067	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	187,854,303	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	259,255,647	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	382,735,578	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	382,735,578	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	641,991,225	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/27/2020 10:31 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		367,731,874		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,498,623				2.00
3.00	Total (sum of line 1 and line 2)		410,230,497		0		3.00
4.00	CHANGE IN TEMP RESTRICTED	331,344		0		0	4.00
5.00	ROUNDING	2		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)		331,346		0		10.00
11.00	Subtotal (line 3 plus line 10)		410,561,843		0		11.00
12.00	PENSION LIABILITY ADJUSTMENT	27,826,265		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)		27,826,265		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		382,735,578		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	CHANGE IN TEMP RESTRICTED		0				4.00
5.00	ROUNDING		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	PENSION LIABILITY ADJUSTMENT		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: 14-0015

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	104,819,248		104,819,248	1.00
2.00	SUBPROVIDER - IPF	28,389,592		28,389,592	2.00
3.00	SUBPROVIDER - IRF	6,152,253		6,152,253	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	6,280,808		6,280,808	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)	145,641,901		145,641,901	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	40,122,859		40,122,859	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)	40,122,859		40,122,859	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	185,764,760		185,764,760	17.00
18.00	Ancillary services	485,304,752	767,012,023	1,252,316,775	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,558,541	1,558,541	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		6,907,889	6,907,889	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	62,934	3,711,030	3,773,964	26.00
27.00	NURSERY	3,818,307	0	3,818,307	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	674,950,753	779,189,483	1,454,140,236	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		403,015,763		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)		403,015,763		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/27/2020 10:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,454,140,236	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,042,627,636	2.00
3.00	Net patient revenues (line 1 minus line 2)	411,512,600	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	403,015,763	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,496,837	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,315,570	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,745,411	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	84,222	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	5,016,003	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	808,404	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	14,579,589	24.00
24.01	TRANSFERS	1,006,527	24.01
24.02	TRANSFERS	1,446,060	24.02
25.00	Total other income (sum of lines 6-24)	34,001,786	25.00
26.00	Total (line 5 plus line 25)	42,498,623	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)	42,498,623	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015

Period:

Worksheet H

HHA CCN: 14-7031

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/27/2020 10:31 pm

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	635,452	0	0	0	635,452	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,075,560	0	142,729	0	459,935	6.00
7.00	Physical Therapy	846,493	0	77,595	0	250,044	7.00
8.00	Occupational Therapy	232,653	0	22,424	0	72,259	8.00
9.00	Speech Pathology	28,247	0	2,609	0	8,406	9.00
10.00	Medical Social Services	88,111	0	361	0	1,163	10.00
11.00	Home Health Aide	184,624	0	31,804	0	102,486	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,091,140	0	277,522	0	894,293	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-7,661	627,791	-10,490	617,301		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,678,224	0	1,678,224		6.00
7.00	Physical Therapy	0	1,174,132	0	1,174,132		7.00
8.00	Occupational Therapy	0	327,336	0	327,336		8.00
9.00	Speech Pathology	0	39,262	0	39,262		9.00
10.00	Medical Social Services	0	89,635	0	89,635		10.00
11.00	Home Health Aide	0	318,914	0	318,914		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-7,661	4,255,294	-10,490	4,244,804		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/27/2020 10:31 pm

Home Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00				
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	617,301	0	0	0	0	617,301	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,678,224	0	0	0	0	1,678,224	6.00
7.00	Physical Therapy	1,174,132	0	0	0	0	1,174,132	7.00
8.00	Occupational Therapy	327,336	0	0	0	0	327,336	8.00
9.00	Speech Pathology	39,262	0	0	0	0	39,262	9.00
10.00	Medical Social Services	89,635	0	0	0	0	89,635	10.00
11.00	Home Health Aide	318,914	0	0	0	0	318,914	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,244,804	0	0	0	0	4,244,804	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	617,301						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	285,590	1,963,814					6.00
7.00	Physical Therapy	199,804	1,373,936					7.00
8.00	Occupational Therapy	55,703	383,039					8.00
9.00	Speech Pathology	6,681	45,943					9.00
10.00	Medical Social Services	15,253	104,888					10.00
11.00	Home Health Aide	54,270	373,184					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		4,244,804					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet H-1

HHA CCN: 14-7031

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 10:31 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-617,301	3,627,503
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	1,678,224	6.00
7.00	Physical Therapy	0	0	0	0	1,174,132	7.00
8.00	Occupational Therapy	0	0	0	0	327,336	8.00
9.00	Speech Pathology	0	0	0	0	39,262	9.00
10.00	Medical Social Services	0	0	0	0	89,635	10.00
11.00	Home Health Aide	0	0	0	0	318,914	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-617,301	3,627,503
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		617,301
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.170172

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	MOB PHASE I	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	1,963,814	0	0	0	0	0	2.00
3.00	Physical Therapy	1,373,936	0	0	0	0	0	3.00
4.00	Occupational Therapy	383,039	0	0	0	0	0	4.00
5.00	Speech Pathology	45,943	0	0	0	0	0	5.00
6.00	Medical Social Services	104,888	0	0	0	0	0	6.00
7.00	Home Health Aide	373,184	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,244,804	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		OAK STREET MALL	BRCN AT 36TH ST	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		1.05	1.06	2.00	4.00	4A	5.00	
1.00	Administrative and General	27,614	0	641	121,314	149,569	43,499	1.00
2.00	Skilled Nursing Care	0	0	0	205,333	2,169,147	630,851	2.00
3.00	Physical Therapy	0	0	0	161,603	1,535,539	446,579	3.00
4.00	Occupational Therapy	0	0	0	44,416	427,455	124,316	4.00
5.00	Speech Pathology	0	0	0	5,393	51,336	14,930	5.00
6.00	Medical Social Services	0	0	0	16,821	121,709	35,397	6.00
7.00	Home Health Aide	0	0	0	35,246	408,430	118,783	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	27,614	0	641	590,126	4,863,185	1,414,355	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:

2/27/2020 10:31 pm

Home Health
Agency I

PPS

Cost Center Description		MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	47,709	0	24,976	0	0	842,515	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	47,709	0	24,976	0	0	842,515	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		16.00	20.00	21.00	22.00	23.00	23.01	
1.00	Administrative and General	0	17,129	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	17,129	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015

Period:

Worksheet H-2

HHA CCN: 14-7031

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 10:31 pmHome Health
Agency I

PPS

Cost Center Description		PARAMED ED PRGM-LABORATOR Y	PARAMED ED PRGM-PHARMACY	PARAMED ED PRGM-RESPIRATO RY	PARAMED ED PRGM-HIM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.02	23.03	23.04	23.05	24.00	25.00	
1.00	Administrative and General	0	0	0	0	1,125,397	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,799,998	0	2.00
3.00	Physical Therapy	0	0	0	0	1,982,118	0	3.00
4.00	Occupational Therapy	0	0	0	0	551,771	0	4.00
5.00	Speech Pathology	0	0	0	0	66,266	0	5.00
6.00	Medical Social Services	0	0	0	0	157,106	0	6.00
7.00	Home Health Aide	0	0	0	0	527,213	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	7,209,869	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	1,125,397						1.00
2.00	Skilled Nursing Care	2,799,998	517,893	3,317,891				2.00
3.00	Physical Therapy	1,982,118	366,617	2,348,735				3.00
4.00	Occupational Therapy	551,771	102,057	653,828				4.00
5.00	Speech Pathology	66,266	12,257	78,523				5.00
6.00	Medical Social Services	157,106	29,059	186,165				6.00
7.00	Home Health Aide	527,213	97,514	624,727				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	7,209,869	1,125,397	7,209,869				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.184962					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015
HHA CCN: 14-7031Period:
From 10/01/2018
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Cost Center Description		CAPITAL RELATED COSTS		Agency 1				
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	OAK STREET MALL (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	0	2,050	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	2,050	20.00
21.00	Total cost to be allocated	0	0	0	0	0	27,614	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	13.470244	22.00
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BRCN AT 36TH ST (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.06	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	641	635,452	0	149,569	2,050	1.00
2.00	Skilled Nursing Care	0	0	1,075,560	0	2,169,147	0	2.00
3.00	Physical Therapy	0	0	846,493	0	1,535,539	0	3.00
4.00	Occupational Therapy	0	0	232,653	0	427,455	0	4.00
5.00	Speech Pathology	0	0	28,247	0	51,336	0	5.00
6.00	Medical Social Services	0	0	88,111	0	121,709	0	6.00
7.00	Home Health Aide	0	0	184,624	0	408,430	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	641	3,091,140		4,863,185	2,050	20.00
21.00	Total cost to be allocated	0	641	590,126		1,414,355	47,709	21.00
22.00	Unit cost multiplier	0.000000	1.000000	0.190909		0.290829	23.272683	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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HHA CCN: 14-7031Period:
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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	503	0	0	94,681	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	503	0	0	94,681	0	20.00
21.00	Total cost to be allocated	0	24,976	0	0	842,515	0	21.00
22.00	Unit cost multiplier	0.000000	49.654076	0.000000	0.000000	8.898459	0.000000	22.00
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
		20.00	21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	88	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	88	0	0	0	0	0	20.00
21.00	Total cost to be allocated	17,129	0	0	0	0	0	21.00
22.00	Unit cost multiplier	194.647727	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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Cost Center Description		PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	PARAMED ED PRGM-RESPIRATO RY (ASSIGNED TIME)	PARAMED ED PRGM-HIM (TIME SPENT)		
		23.03	23.04	23.05		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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HHA CCN: 14-7031

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Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	3,317,891		3,317,891	21,881	151.63	1.00
2.00	Physical Therapy	3.00	2,348,735	0	2,348,735	11,895	197.46	2.00
3.00	Occupational Therapy	4.00	653,828	0	653,828	3,436	190.29	3.00
4.00	Speech Pathology	5.00	78,523	0	78,523	402	195.33	4.00
5.00	Medical Social Services	6.00	186,165		186,165	56	3,324.38	5.00
6.00	Home Health Aide	7.00	624,727		624,727	4,874	128.18	6.00
7.00	Total (sum of lines 1-6)		7,209,869	0	7,209,869	42,544		7.00

Program Visits

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation

8.00	Skilled Nursing Care		99914	0	9,880		8.00
8.01	Skilled Nursing Care		99926	0	2,587		8.01
8.02	Skilled Nursing Care		17860	0	10		8.02
9.00	Physical Therapy		99914	0	5,584		9.00
9.01	Physical Therapy		99926	0	1,973		9.01
9.02	Physical Therapy		17860	0	13		9.02
10.00	Occupational Therapy		99914	0	1,750		10.00
10.01	Occupational Therapy		99926	0	241		10.01
10.02	Occupational Therapy		17860	0	0		10.02
11.00	Speech Pathology		99914	0	170		11.00
11.01	Speech Pathology		99926	0	28		11.01
11.02	Speech Pathology		17860	0	0		11.02
12.00	Medical Social Services		99914	0	26		12.00
12.01	Medical Social Services		99926	0	2		12.01
12.02	Medical Social Services		17860	0	0		12.02
13.00	Home Health Aide		99914	0	2,746		13.00
13.01	Home Health Aide		99926	0	627		13.01
13.02	Home Health Aide		17860	0	0		13.02
14.00	Total (sum of lines 8-13)			0	25,637		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	0	0	1,245,848	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	0	12,477	0	1,891,888		1.00
2.00	Physical Therapy	0	7,570	0	1,494,772		2.00
3.00	Occupational Therapy	0	1,991	0	378,867		3.00
4.00	Speech Pathology	0	198	0	38,675		4.00
5.00	Medical Social Services	0	28	0	93,083		5.00
6.00	Home Health Aide	0	3,373	0	432,351		6.00
7.00	Total (sum of lines 1-6)	0	25,637	0	4,329,636		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
8.02	Skilled Nursing Care								8.02
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
9.02	Physical Therapy								9.02
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
10.02	Occupational Therapy								10.02
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
11.02	Speech Pathology								11.02
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
12.02	Medical Social Services								12.02
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
13.02	Home Health Aide								13.02
14.00	Total (sum of lines 8-13)								14.00
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	1,245,848	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
		Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,891,888							1.00
2.00	Physical Therapy	1,494,772							2.00
3.00	Occupational Therapy	378,867							3.00
4.00	Speech Pathology	38,675							4.00
5.00	Medical Social Services	93,083							5.00
6.00	Home Health Aide	432,351							6.00
7.00	Total (sum of lines 1-6)	4,329,636							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
8.02	Skilled Nursing Care								8.02
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
9.02	Physical Therapy								9.02
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
10.02	Occupational Therapy								10.02
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
11.02	Speech Pathology								11.02
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
12.02	Medical Social Services								12.02
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
13.02	Home Health Aide								13.02
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.464630	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.365071	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.279478	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.153960	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.152505	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2018 To 09/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	5,160,654	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	5,160,654	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	5,160,654	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	4,548	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-4,548
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	3,721,047
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	70,323
13.00	Total PPS Reimbursement - LUPA Episodes		0	53,123
14.00	Total PPS Reimbursement - PEP Episodes		0	28,109
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	20,428
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	3,888,482
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	3,888,482
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	3,888,482
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,888,482
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	3,888,482
31.01	Sequestration adjustment (see instructions)		0	77,770
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	3,810,712
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0015

Period:

Worksheet H-5

HHA CCN: 14-7031

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pmHome Health
Agency I

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		0		3,810,712	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			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			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. H-4, Part II, column as appropriate, line 32)		0		3,810,712	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		3,810,712	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/27/2020 10:31 pm

						Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00		
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00		
4.00	ADMINISTRATIVE & GENERAL*	273,357	60,418	333,775	3,866	337,641	4.00		
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00		
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00		
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00		
8.00	DIETARY*	0	0	0	0	0	8.00		
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00		
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00		
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00		
12.00	STAFF TRANSPORTATION*	0	84,671	84,671	0	84,671	12.00		
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	15,342	15,342	13.00		
14.00	PHARMACY*	0	0	0	0	0	14.00		
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00		
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00		
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00		
DIRECT PATIENT CARE SERVICE COST CENTERS									
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00		
26.00	PHYSICIAN SERVICES**	0	32,742	32,742	0	32,742	26.00		
27.00	NURSE PRACTITIONER**	33,335	0	33,335	0	33,335	27.00		
28.00	REGISTERED NURSE**	511,707	0	511,707	-4,231	507,476	28.00		
29.00	LPN/LVN**	0	0	0	0	0	29.00		
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00		
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00		
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00		
33.00	MEDICAL SOCIAL SERVICES**	136,203	0	136,203	0	136,203	33.00		
34.00	SPIRITUAL COUNSELING**	71,998	0	71,998	0	71,998	34.00		
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00		
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	86,009	0	86,009	0	86,009	37.00		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	76,093	76,093	0	76,093	38.00		
39.00	PATIENT TRANSPORTATION**	0	4,822	4,822	0	4,822	39.00		
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00		
41.00	LABS & DIAGNOSTICS**	0	76	76	0	76	41.00		
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	27,427	27,427	0	27,427	42.00		
42.50	DRUGS CHARGED TO PATIENTS**	0	111,263	111,263	0	111,263	42.50		
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00		
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00		
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	2,369	0	2,369	0	2,369	46.00		
NONREIMBURSABLE COST CENTERS									
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00		
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00		
62.00	FUNDRAISING*	0	0	0	0	0	62.00		
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00		
64.00	PALLIATIVE CARE PROGRAM*	76,436	0	76,436	0	76,436	64.00		
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00		
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00		
67.00	ADVERTISING*	0	0	0	0	0	67.00		
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00		
69.00	THRIFT STORE*	0	0	0	0	0	69.00		
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00		
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00		
100.00	TOTAL	1,191,414	397,512	1,588,926	14,977	1,603,903	100.00		

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	337,641		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	84,671		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	15,342		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	178,957	178,957		25.00
26.00	PHYSICIAN SERVICES**	-4,169	28,573		26.00
27.00	NURSE PRACTITIONER**	0	33,335		27.00
28.00	REGISTERED NURSE**	0	507,476		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	136,203		33.00
34.00	SPIRITUAL COUNSELING**	0	71,998		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	86,009		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	76,093		38.00
39.00	PATIENT TRANSPORTATION**	0	4,822		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	76		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	27,427		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	111,263		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	2,369		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	76,436		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	174,788	1,778,691		100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0015

Period:

Worksheet 0-2

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

				Hospice I		2/27/2025 10:01 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	32,742	32,742	0	32,742	26.00
27.00	NURSE PRACTITIONER	33,335	0	33,335	0	33,335	27.00
28.00	REGISTERED NURSE	473,987	0	473,987	-4,231	469,756	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	130,026	0	130,026	0	130,026	33.00
34.00	SPIRITUAL COUNSELING	69,169	0	69,169	0	69,169	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	85,609	0	85,609	0	85,609	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	76,093	76,093	0	76,093	38.00
39.00	PATIENT TRANSPORTATION	0	4,822	4,822	0	4,822	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	76	76	0	76	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	27,379	27,379	0	27,379	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	111,069	111,069	0	111,069	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	2,369	0	2,369	0	2,369	46.00
100.00	TOTAL *	794,495	252,181	1,046,676	-4,231	1,042,445	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	-4,169	28,573	26.00
27.00	NURSE PRACTITIONER	0	33,335	27.00
28.00	REGISTERED NURSE	0	469,756	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	130,026	33.00
34.00	SPIRITUAL COUNSELING	0	69,169	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	85,609	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	76,093	38.00
39.00	PATIENT TRANSPORTATION	0	4,822	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	76	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	27,379	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	111,069	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2,369	46.00
100.00	TOTAL *	-4,169	1,038,276	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0015

Period:

Worksheet 0-3

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

				Hospice I		2/27/2020 10:01 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,542	0	1,542	0	1,542	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	842	0	842	0	842	33.00
34.00	SPIRITUAL COUNSELING	189	0	189	0	189	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	400	0	400	0	400	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	48	48	0	48	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	194	194	0	194	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	2,973	242	3,215	0	3,215	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	3,721	3,721	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,542	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	842	33.00
34.00	SPIRITUAL COUNSELING	0	189	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	400	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	48	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	194	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	3,721	6,936	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0015

Period:

Worksheet 0-4

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

				Hospice I		2/27/2020 10:01 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	36,178	0	36,178	0	36,178	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,335	0	5,335	0	5,335	33.00
34.00	SPIRITUAL COUNSELING	2,640	0	2,640	0	2,640	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	44,153	0	44,153	0	44,153	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	175,236	175,236	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	36,178	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,335	33.00
34.00	SPIRITUAL COUNSELING	0	2,640	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	175,236	219,389	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0015

Period:

Worksheet 0-5

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,110	10,110	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	228,977	228,977	3.00
4.00	ADMINISTRATIVE & GENERAL	337,641	586,828	924,469	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	343,427	343,427	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	84,671	0	84,671	12.00
13.00	VOLUNTEER SERVICE COORDINATION	15,342	0	15,342	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	26,277	26,277	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,038,276	0	1,038,276	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6,936	0	6,936	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	219,389	0	219,389	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	76,436	0	76,436	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	1,778,691	1,195,619	2,974,310	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,110			10,110			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	228,977		0	0	228,977		3.00
4.00	ADMINISTRATIVE & GENERAL	924,469		0	10,110	52,186	986,765	4.00
5.00	PLANT OPERATION & MAINTENANCE	0		0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0		0	0	0	0	6.00
7.00	HOUSEKEEPING	0		0	0	0	0	7.00
8.00	DIETARY	0		0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	343,427		0	0	0	343,427	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0	0	0	0	10.00
11.00	MEDICAL RECORDS	0		0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	84,671		0	0	0	84,671	12.00
13.00	VOLUNTEER SERVICE COORDINATION	15,342		0	0	2,333	17,675	13.00
14.00	PHARMACY	0		0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	26,277		0	0	0	26,277	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0		0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,038,276				150,869	1,189,145	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6,936		0	0	568	7,504	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	219,389		0	0	8,429	227,818	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0		0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0		0	0	0	0	61.00
62.00	FUNDRAISING	0		0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	76,436		0	0	14,592	91,028	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	2,974,310		0	10,110	228,977	2,974,310	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00		5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	986,765						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	170,503	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	42,037	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	8,775	0			0		13.00
14.00	PHARMACY	0	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	13,046	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	590,379						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,726	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	113,106	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	45,193	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	986,765	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	513,930					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			126,708		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	26,450	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	494,208	0	0	121,846	25,474	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	866	0	0	213	4	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	18,856	0	0	4,649	972	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	513,930	0	0	126,708	26,450	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 10:31 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		39,323			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	39,323		2,460,375	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	12,313	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	365,401	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		136,221	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	39,323	0	2,974,310	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		10,108				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,199,402			3.00
4.00	ADMINISTRATIVE & GENERAL	0	10,108	273,357	-986,765	1,987,545	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	343,427	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	84,671	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	12,219	0	17,675	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	26,277	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			790,264	0	1,189,145	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	2,973	0	7,504	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	44,153	0	227,818	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	76,436	0	91,028	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	10,110	228,977		986,765	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.000198	0.190909		0.496474	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		38,594	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					37,113	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	65	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1,416	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	513,930	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	13.316319	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0				10.00
11.00	MEDICAL RECORDS		0			11.00
12.00	STAFF TRANSPORTATION			38,594		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	38,535	13.00
14.00	PHARMACY			0	0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	37,113	37,113	0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	65	6	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,416	1,416	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	126,708	26,450	0 100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	3.283101	0.686389	0.000000 101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015

Period:

Worksheet 0-6

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/27/2020 10:31 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		100			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	100			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	39,323	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	393.230000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2018
To 09/30/2019

Worksheet 0-7
Date/Time Prepared:
2/27/2020 10:31 pm

				Hospice I			
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1.00	PHYSICAL THERAPY	66.00	0.464630	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.365071	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.279478	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.152505	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.082723	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.153960	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.193303	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015

Period:

Worksheet 0-8

Hospice CCN: 14-1501

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,460,375	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			13,180	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			186.67	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	12,042	286		9.00
10.00	Program cost (line 8 times line 9)	2,247,880	53,388		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			12,313	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			23	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			535.35	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	23	0		14.00
15.00	Program cost (line 13 times line 14)	12,313	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			365,401	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			503	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			726.44	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	370	69		19.00
20.00	Program cost (line 18 times line 19)	268,783	50,124		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			2,838,089	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			13,706	22.00
23.00	Average cost per diem (line 21 divided by line 22)			207.07	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0015	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/27/2020 10:31 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,090,333	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		151,432	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)		124.11	3.00
4.00	Number of interns & residents (see instructions)		13.16	4.00
5.00	Indirect medical education percentage (see instructions)		3.04	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)		124,346	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		4,366,111	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	42,942	0	42,942	0	42,942
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	117,763	0	117,763	0	117,763
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	202,694	0	202,694	0	202,694
10.00	Subtotal (sum of lines 1 through 9)	363,399	0	363,399	0	363,399
11.00	Physician Services Under Agreement	0	251,397	251,397	0	251,397
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	92	92	0	92
14.00	Subtotal (sum of lines 11 through 13)	0	251,489	251,489	0	251,489
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	54,276	54,276	-1,158	53,118
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	54,276	54,276	-1,158	53,118
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	363,399	305,765	669,164	-1,158	668,006
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	93,182	93,182	5,623	98,805
30.00	Administrative Costs	91,078	26,562	117,640	0	117,640
31.00	Total Facility Overhead (sum of lines 29 and 30)	91,078	119,744	210,822	5,623	216,445
32.00	Total facility costs (sum of lines 22, 28 and 31)	454,477	425,509	879,986	4,465	884,451

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015

Period:

Worksheet M-1

Component CCN: 14-3422

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	42,942	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	117,763	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	0	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	202,694	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	363,399	10.00	
11.00	Physician Services Under Agreement	0	251,397	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	92	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	251,489	14.00	
15.00	Medical Supplies	0	0	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	53,118	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	53,118	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	668,006	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	-49,284	49,521	29.00	
30.00	Administrative Costs	-135	117,505	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-49,419	167,026	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-49,419	835,032	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015

Period:

Worksheet M-2

Component CCN: 14-3422

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:31 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.79	1,719	4,200	3,318		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	681	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.69	2,400		5,208	5,208	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.35	374			374	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.04	2,774			5,582	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					668,006	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					668,006	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					167,026	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					354,849	15.00
16.00	Total overhead (sum of lines 14 and 15)					521,875	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					521,875	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					521,875	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,189,881	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,189,881	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			50,741	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,139,140	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,582	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,582	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			204.07	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		418	1,183	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		34,882	100,200	11.00
12.00	Program covered visits for mental health services (from contractor records)		27	49	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		2,253	4,150	13.00
14.00	Limit adjustment for mental health services (see instructions)		2,253	4,150	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	141,485	16.00
16.01	Total program charges (see instructions)(from contractor's records)			367,303	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			495	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			191	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			88,083	16.04
16.05	Total program cost (see instructions)		0	88,274	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			31,190	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			67,124	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			88,274	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			21,289	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			109,563	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			109,563	26.00
26.01	Sequestration adjustment (see instructions)			2,191	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			83,432	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			23,940	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 10:31 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		363,399	363,399	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001561	0.005470	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		567	1,988	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19,668	6,263	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,235	8,251	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		668,006	668,006	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		521,875	521,875	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.030292	0.012352	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		15,809	6,446	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		36,044	14,697	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		133	466	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		271.01	31.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		59	168	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		15,990	5,299	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			50,741	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			21,289	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 10:31 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		83,432	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		83,432	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		23,940	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		107,372	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00