

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: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 2:13 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH ST. MARY'S HOSPITAL (14-0034) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) EILEEN LAMM
 Officer or Administrator of Provider(s)

VP OF FINANCE
 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	13,806	7,856	0	0	1.00
2.00	Subprovider - IPF	0	57,384	1		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.30	OOT I	0		0		0	12.30
200.00	Total	0	71,190	7,857	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: 14-0034		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 2:13 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 400 NORTH PLEASANT AVENUE			PO Box:				1.00	
2.00	City: CENTRALIA			State: IL		Zip Code: 62801-		County: MARION 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SSM HEALTH ST. MARY'S HOSPITAL	140034	99914	1	07/01/1966	N P P
4.00	Subprovider - IPF			SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	N P P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.30	Hospital-Based (OOT) I			ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N O N
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	
21.00	Type of Control (see instructions)						1		
							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)					Y	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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

Worksheet S-2
Part I
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8/27/2020 2:13 pm

MCRIF32 - 16.2.168.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		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
61.01	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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y	N	0		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
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:	51,150	8,268	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	269020	140.00

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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: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301		141.00		
142.00	Street: 10101 WOODFIELD LANE	PO Box:				142.00		
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		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	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.				Y	11/11/2019	146.00	
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					Y	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	
161.01			N	N	N		161.01	
161.30	OOT		N	N	N		161.30	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00	
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00	
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 2:13 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?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		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	04/03/2017	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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	LAMOND		41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162	ERIC.LAMOND@SSMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - GVERNEMENT REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:13 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	84	30,660	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)		84	30,660	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		92	33,580	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	99.30				0	25.30
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		116				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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:13 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)	7,732	233	11,775			1.00
2.00	HMO and other (see instructions)	981	2,009				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,732	233	11,775			7.00
8.00	INTENSIVE CARE UNIT	838	45	1,304			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		183	484			13.00
14.00	Total (see instructions)	8,570	461	13,563	0.00	498.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,528	632	5,250	0.00	33.13	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	531.45	27.00
28.00	Observation Bed Days		93	2,430			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			145			31.00
32.00	Labor & delivery days (see instructions)	0	99	119			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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,993	269	4,133	1.00
2.00 HMO and other (see instructions)			242	800		2.00
3.00 HMO IPF Subprovider				454		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,993	269	4,133	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	216	158	1,111	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	0.00					25.30
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 2:13 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	32,213,970	0	32,213,970	1,105,419.25	29.14
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,184,785	-50,067	2,134,718	72,618.73	29.40
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		676,043	0	676,043	23,383.66	28.91
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		0	0	0	0.00	0.00
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		3,780,797	0	3,780,797	104,793.59	36.08
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,434,003	0	14,434,003		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		850,527	0	850,527		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,351,524	0	1,351,524		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 2:13 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	306,014	0	306,014	2,680.75	114.15	26.00
27.00	Administrative & General	5.00	2,285,000	0	2,285,000	69,567.71	32.85	27.00
28.00	Administrative & General under contract (see inst.)		243,579	0	243,579	1,237.23	196.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	738,717	0	738,717	30,328.28	24.36	30.00
31.00	Laundry & Linen Service	8.00	92,083	0	92,083	5,966.16	15.43	31.00
32.00	Housekeeping	9.00	970,274	0	970,274	68,321.80	14.20	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	821,158	-579,080	242,078	14,550.20	16.64	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	579,080	579,080	34,805.99	16.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	902,029	0	902,029	22,275.02	40.50	38.00
39.00	Central Services and Supply	14.00	301,371	0	301,371	14,162.15	21.28	39.00
40.00	Pharmacy	15.00	1,151,239	0	1,151,239	29,725.41	38.73	40.00
41.00	Medical Records & Medical Records Library	16.00	160,445	0	160,445	10,665.74	15.04	41.00
42.00	Social Service	17.00	702,011	0	702,011	21,986.32	31.93	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/27/2020 2:13 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)	32,457,549	0	32,457,549	1,106,656.48	29.33	1.00
2.00	Excluded area salaries (see instructions)	2,184,785	-50,067	2,134,718	72,618.73	29.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,272,764	50,067	30,322,831	1,034,037.75	29.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,456,840	0	4,456,840	128,177.25	34.77	4.00
5.00	Subtotal wage-related costs (see inst.)	15,785,527	0	15,785,527	0.00	52.06	5.00
6.00	Total (sum of lines 3 thru 5)	50,515,131	50,067	50,565,198	1,162,215.00	43.51	6.00
7.00	Total overhead cost (see instructions)	8,673,920	0	8,673,920	326,272.76	26.58	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/27/2020 2:13 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,042,666 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)			2,043,000 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)			7,832,979 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			452,986 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			185,948 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)			164,389 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			90,167 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,337,612 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			60,403 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			954,191 22.00
23.00	Tuition Reimbursement			120,189 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			15,284,530 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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/27/2020 2:13 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	676,043	15,284,530	1.00
2.00	Hospital	676,043	14,434,003	2.00
3.00	Subprovider - IPF	0	53,158	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.30	Hospital-Based-CMHC 30	0	0	16.30
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	797,369	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0034

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

Worksheet S-5

Date/Time Prepared:
8/27/2020 2:13 pm

		Outpatient		Training		Home			
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00	5.00	6.00		
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00	
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00	
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00	
4.00	CAPD exchanges per day				0.00		0.00	4.00	
5.00	Number of days in year dialysis furnished	0	0					5.00	
6.00	Number of stations	0	0	0	0			6.00	
7.00	Treatment capacity per day per station	0	0					7.00	
8.00	Utilization (see instructions)	0.00	0.00					8.00	
9.00	Average times dialyzers re-used	0.00	0.00					9.00	
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00	
							Y/N		
							1.00		
ESRD PPS									
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02	
						Prior to 1/1	After 12/31		
						1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	0	10.03
TRANSPLANT INFORMATION									
11.00	Number of patients on transplant list						0	11.00	
12.00	Number of patients transplanted during the cost reporting period						0	12.00	
EPOETIN									
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00	
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00	
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00	
16.00	Number of EPO units furnished relating to the home dialysis department							16.00	
ARANESP									
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00	
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00	
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00	
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00	
						MCP	INITIAL METHOD		
						1.00	2.00		
PHYSICIAN PAYMENT METHOD									
21.00	Enter "X" if method(s) is applicable						X	21.00	
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.			
		1.00	2.00	3.00	4.00	5.00			
ESAs									
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)			0	0	0	0	22.00	

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0034

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

Worksheet S-5

Date/Time Prepared:
8/27/2020 2:13 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0034

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

Worksheet S-10

Date/Time Prepared:
8/27/2020 2:13 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)			0.260096	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			9,327,705	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			10,855,782	5.00
6.00	Medicaid charges			81,133,851	6.00
7.00	Medicaid cost (line 1 times line 6)			21,102,590	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)			919,103	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)			919,103	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)	3,405,206	1,797,958	5,203,164	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	885,680	1,797,958	2,683,638	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)	885,680	1,797,958	2,683,638	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)			2,587,788	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			599,363	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			922,097	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,665,691	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			755,974	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,439,612	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,358,715	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
8/27/2020 2:13 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		3,953,439	3,953,439	142,530	4,095,969	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,339,388	2,339,388	0	2,339,388	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	306,014	15,507,652	15,813,666	0	15,813,666	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,285,000	17,461,614	19,746,614	-209,478	19,537,136	5.00
7.00	00700	OPERATION OF PLANT	738,717	3,314,955	4,053,672	182,210	4,235,882	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,083	303,172	395,255	0	395,255	8.00
9.00	00900	HOUSEKEEPING	970,274	302,991	1,273,265	-105,936	1,167,329	9.00
10.00	01000	DIETARY	821,158	464,857	1,286,015	-913,840	372,175	10.00
11.00	01100	CAFETERIA	0	0	0	913,840	913,840	11.00
13.00	01300	NURSING ADMINISTRATION	902,029	124,042	1,026,071	0	1,026,071	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	301,371	214,930	516,301	-25,380	490,921	14.00
15.00	01500	PHARMACY	1,151,239	4,509,667	5,660,906	-4,266,682	1,394,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,445	122,370	282,815	0	282,815	16.00
17.00	01700	SOCIAL SERVICE	702,011	294,066	996,077	-94	995,983	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,752,785	700,505	6,453,290	703,815	7,157,105	30.00
31.00	03100	INTENSIVE CARE UNIT	1,614,027	696,435	2,310,462	-751,218	1,559,244	31.00
40.00	04000	SUBPROVIDER - IPF	2,013,379	107,064	2,120,443	-18,309	2,102,134	40.00
43.00	04300	NURSERY	0	0	0	553,209	553,209	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,797,103	2,659,059	4,456,162	-2,125,026	2,331,136	50.00
51.00	05100	RECOVERY ROOM	259,889	31,524	291,413	-8,740	282,673	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,075,664	166,556	1,242,220	-1,156,678	85,542	52.00
53.00	05300	ANESTHESIOLOGY	8,749	2,865,907	2,874,656	-157,714	2,716,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,032,301	108,375	1,140,676	-57,435	1,083,241	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	409,266	873,642	1,282,908	-6,167	1,276,741	55.00
56.00	05600	RADIOISOTOPE	162,984	284,493	447,477	-1,713	445,764	56.00
57.00	05700	CT SCAN	328,574	88,130	416,704	-76,110	340,594	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	133,060	42,648	175,708	-13,265	162,443	58.00
59.00	05900	CARDIAC CATHETERIZATION	103,899	116,263	220,162	-95,578	124,584	59.00
60.00	06000	LABORATORY	1,558,130	2,171,705	3,729,835	-68,735	3,661,100	60.00
64.00	06400	INTRAVENOUS THERAPY	269,368	43,919	313,287	-35,012	278,275	64.00
65.00	06500	RESPIRATORY THERAPY	990,239	183,339	1,173,578	-50,886	1,122,692	65.00
66.00	06600	PHYSICAL THERAPY	1,167,818	117,118	1,284,936	25,809	1,310,745	66.00
66.01	03340	CLINICAL NUTRITION	171,099	467	171,566	0	171,566	66.01
67.00	06700	OCCUPATIONAL THERAPY	124,865	2,446	127,311	4,533	131,844	67.00
68.00	06800	SPEECH PATHOLOGY	104,755	1,476	106,231	3,466	109,697	68.00
69.00	06900	ELECTROCARDIOLOGY	830,330	354,926	1,185,256	-15,903	1,169,353	69.00
69.01	03140	CARDIAC REHABILITATION	95,633	2,377	98,010	-644	97,366	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	102,287	169,706	271,993	-3,085	268,908	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,172,544	3,172,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	543,744	543,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,340,555	4,340,555	73.00
74.00	07400	RENAL DIALYSIS	0	147,157	147,157	-1,095	146,062	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,483,062	1,123,740	2,606,802	-18,190	2,588,612	90.00
91.00	09100	EMERGENCY	2,022,957	1,822,780	3,845,737	-353,268	3,492,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	50,067	7	50,074	-50,074	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,092,631	63,794,907	95,887,538	0	95,887,538	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,217	0	33,217	0	33,217	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,922	50,922	0	50,922	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	88,122	114,643	202,765	0	202,765	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	201,525	201,525	0	201,525	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	32,213,970	64,161,997	96,375,967	0	96,375,967	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
8/27/2020 2:13 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	33,346	4,129,315	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-16,224	2,323,164	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	159,088	15,972,754	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,496,943	14,040,193	5.00
7.00	00700	OPERATION OF PLANT	-791,763	3,444,119	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	395,255	8.00
9.00	00900	HOUSEKEEPING	-74,516	1,092,813	9.00
10.00	01000	DIETARY	0	372,175	10.00
11.00	01100	CAFETERIA	-277,093	636,747	11.00
13.00	01300	NURSING ADMINISTRATION	-436	1,025,635	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	490,921	14.00
15.00	01500	PHARMACY	-21,465	1,372,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,078	277,737	16.00
17.00	01700	SOCIAL SERVICE	0	995,983	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-574,847	6,582,258	30.00
31.00	03100	INTENSIVE CARE UNIT	-9,369	1,549,875	31.00
40.00	04000	SUBPROVIDER - IPF	-51,902	2,050,232	40.00
43.00	04300	NURSERY	0	553,209	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-34,376	2,296,760	50.00
51.00	05100	RECOVERY ROOM	0	282,673	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-10	85,532	52.00
53.00	05300	ANESTHESIOLOGY	-2,640,802	76,140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,193	1,082,048	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-551,881	724,860	55.00
56.00	05600	RADIOISOTOPE	-22,560	423,204	56.00
57.00	05700	CT SCAN	0	340,594	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	162,443	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	124,584	59.00
60.00	06000	LABORATORY	-201,483	3,459,617	60.00
64.00	06400	INTRAVENOUS THERAPY	0	278,275	64.00
65.00	06500	RESPIRATORY THERAPY	-43,295	1,079,397	65.00
66.00	06600	PHYSICAL THERAPY	-82,843	1,227,902	66.00
66.01	03340	CLINICAL NUTRITION	0	171,566	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	131,844	67.00
68.00	06800	SPEECH PATHOLOGY	-2,668	107,029	68.00
69.00	06900	ELECTROCARDIOLOGY	-340,507	828,846	69.00
69.01	03140	CARDIAC REHABILITATION	-11,902	85,464	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-159,194	109,714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-148,749	3,023,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	543,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,340,555	73.00
74.00	07400	RENAL DIALYSIS	-27,205	118,857	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-848,219	1,740,393	90.00
91.00	09100	EMERGENCY	-1,380,756	2,111,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT	0	0	99.30
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,624,845	82,262,693	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,217	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,922	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	202,765	194.00
194.01	07951	NON-REIMBURSABLE	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	201,525	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,624,845	82,751,122	200.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 2:13 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY AND L&D					
1.00	ADULTS & PEDIATRICS	30.00	838,254	289,864		1.00
2.00	NURSERY	43.00	436,891	116,318		2.00
	TOTALS		1,275,145	406,182		
	C - MEALS					
1.00	CAFETERIA	11.00	579,080	334,760		1.00
	TOTALS		579,080	334,760		
	D - PUMP RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	25,380		1.00
	TOTALS		0	25,380		
	L - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	182,210		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
	TOTALS		0	182,210		
	O - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	142,530		1.00
	TOTALS		0	142,530		
	P - CENTRAL SUPPLY AND IMPL DEV					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,172,544		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	543,744		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
	TOTALS		0	3,716,288		
	R - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,340,555		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	TOTALS		0	4,340,555		
	S - REHAB ADMIN					
1.00	PHYSICAL THERAPY	66.00	41,551	4		1.00
2.00	OCCUPATIONAL THERAPY	67.00	4,668	3		2.00
3.00	SPEECH PATHOLOGY	68.00	3,848	0		3.00
	TOTALS		50,067	7		
500.00	Grand Total: Increases		1,904,292	9,147,912		500.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 2:13 pm

		Decreases					8/27/2020 2:13 PM	
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
A - NURSERY AND L&D								
1.00	INTENSIVE CARE UNIT	31.00	403,553	174,129	0	1.00		
2.00	DELIVERY ROOM & LABOR ROOM	52.00	871,592	232,053	0	2.00		
TOTALS			1,275,145	406,182				
C - MEALS								
1.00	DIETARY	10.00	579,080	334,760	0	1.00		
TOTALS			579,080	334,760				
D - PUMP RECLASS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	25,380	0	1.00		
TOTALS			0	25,380				
L - UTILITIES								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,948	0	1.00		
2.00	HOUSEKEEPING	9.00	0	105,936	0	2.00		
3.00	SOCIAL SERVICE	17.00	0	94	0	3.00		
4.00	PHYSICAL THERAPY	66.00	0	9,197	0	4.00		
5.00	ELECTROCARDIOLOGY	69.00	0	35	0	5.00		
TOTALS			0	182,210				
O - BUILDING INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	142,530	12	1.00		
TOTALS			0	142,530				
P - CENTRAL SUPPLY AND IMPL DEV								
1.00	ADULTS & PEDIATRICS	30.00	0	423,344	0	1.00		
2.00	INTENSIVE CARE UNIT	31.00	0	173,233	0	2.00		
3.00	SUBPROVIDER - IPF	40.00	0	18,309	0	3.00		
4.00	OPERATING ROOM	50.00	0	2,124,690	0	4.00		
5.00	RECOVERY ROOM	51.00	0	8,740	0	5.00		
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	78,178	0	6.00		
7.00	ANESTHESIOLOGY	53.00	0	126,068	0	7.00		
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,742	0	8.00		
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	6,167	0	9.00		
10.00	RADIOISOTOPE	56.00	0	1,713	0	10.00		
11.00	CT SCAN	57.00	0	41,079	0	11.00		
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,265	0	12.00		
13.00	CARDIAC CATHETERIZATION	59.00	0	95,578	0	13.00		
14.00	LABORATORY	60.00	0	68,649	0	14.00		
15.00	INTRAVENOUS THERAPY	64.00	0	34,314	0	15.00		
16.00	RESPIRATORY THERAPY	65.00	0	50,886	0	16.00		
17.00	PHYSICAL THERAPY	66.00	0	6,546	0	17.00		
18.00	OCCUPATIONAL THERAPY	67.00	0	138	0	18.00		
19.00	SPEECH PATHOLOGY	68.00	0	382	0	19.00		
20.00	ELECTROCARDIOLOGY	69.00	0	15,743	0	20.00		
21.00	CARDIAC REHABILITATION	69.01	0	644	0	21.00		
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,085	0	22.00		
23.00	RENAL DIALYSIS	74.00	0	1,095	0	23.00		
24.00	CLINIC	90.00	0	17,432	0	24.00		
25.00	EMERGENCY	91.00	0	353,268	0	25.00		
TOTALS			0	3,716,288				
R - PHARMACY								
1.00	PHARMACY	15.00	0	4,266,682	0	1.00		
2.00	ADULTS & PEDIATRICS	30.00	0	959	0	2.00		
3.00	INTENSIVE CARE UNIT	31.00	0	303	0	3.00		
4.00	OPERATING ROOM	50.00	0	336	0	4.00		
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	235	0	5.00		
6.00	ANESTHESIOLOGY	53.00	0	31,646	0	6.00		
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,693	0	7.00		
8.00	CT SCAN	57.00	0	35,031	0	8.00		
9.00	LABORATORY	60.00	0	86	0	9.00		
10.00	INTRAVENOUS THERAPY	64.00	0	698	0	10.00		
11.00	PHYSICAL THERAPY	66.00	0	3	0	11.00		
12.00	ELECTROCARDIOLOGY	69.00	0	125	0	12.00		
13.00	CLINIC	90.00	0	758	0	13.00		
TOTALS			0	4,340,555				
S - REHAB ADMIN								
1.00	OOT	99.30	50,067	7	0	1.00		
2.00		0.00	0	0	0	2.00		
3.00		0.00	0	0	0	3.00		
TOTALS			50,067	7				
500.00	Grand Total: Decreases		1,904,292	9,147,912		500.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

		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	1,259,000	5,031,781	0	5,031,781	0	1.00	
2.00	Land Improvements	667,527	0	0	0	0	2.00	
3.00	Buildings and Fixtures	34,820,475	565,243	0	565,243	0	3.00	
4.00	Building Improvements	2,968,112	2,871,390	0	2,871,390	15,503	4.00	
5.00	Fixed Equipment	4,821,267	0	0	0	0	5.00	
6.00	Movable Equipment	29,053,968	0	0	0	952,805	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	73,590,349	8,468,414	0	8,468,414	968,308	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	73,590,349	8,468,414	0	8,468,414	968,308	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	6,290,781	1,259,000					1.00
2.00	Land Improvements	667,527	667,527					2.00
3.00	Buildings and Fixtures	35,385,718	39,867,759					3.00
4.00	Building Improvements	5,823,999	2,968,112					4.00
5.00	Fixed Equipment	4,821,267	5,386,510					5.00
6.00	Movable Equipment	28,101,163	32,893,666					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	81,090,455	83,042,574					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	81,090,455	83,042,574					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,021,434	0	1,932,005	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,339,388	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,360,822	0	1,932,005	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	3,953,439				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,339,388				2.00
3.00	Total (sum of lines 1-2)	0	6,292,827				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,688,182	0	38,688,182	0.477099	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,402,273	0	42,402,273	0.522901	0	2.00
3.00	Total (sum of lines 1-2)	81,090,455	0	81,090,455	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,054,780	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,803,851	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,858,631	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,932,005	142,530	0	0	4,129,315	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-480,687	0	0	0	2,323,164	2.00
3.00	Total (sum of lines 1-2)	1,451,318	142,530	0	0	6,452,479	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-976,254	ADMINISTRATIVE & GENERAL	5.00	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	-4,433	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,669,351			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	-4,685,552			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-277,093	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	B	-5,078	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-4,855	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-47,820	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
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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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	MISC REVENUE	B	-380,860	OPERATION OF PLANT	7.00	0	34.00
34.01	MISC REVENUE	B	-74,516	HOUSEKEEPING	9.00	0	34.01
34.02	MISC REVENUE	B	-21,465	PHARMACY	15.00	0	34.02
34.03	MISC REVENUE	B	-6,952	ADULTS & PEDIATRICS	30.00	0	34.03
34.04	MISC REVENUE	B	-434	OPERATING ROOM	50.00	0	34.04
34.05	MISC REVENUE	B	-960	RADIOLOGY-DIAGNOSTIC	54.00	0	34.05
34.06	MISC REVENUE	B	-36,000	RADIOLOGY-THERAPEUTIC	55.00	0	34.06
34.07	MISC REVENUE	B	-137,938	LABORATORY	60.00	0	34.07
34.08	MISC REVENUE	B	-1,524	RESPIRATORY THERAPY	65.00	0	34.08
34.09	MISC REVENUE	B	-33,250	PHYSICAL THERAPY	66.00	0	34.09
34.10	MISC REVENUE	B	-2,668	SPEECH PATHOLOGY	68.00	0	34.10
34.11	MISC REVENUE	B	-156	ELECTROCARDIOLOGY	69.00	0	34.11
34.12	MISC REVENUE	B	-11,902	CARDIAC REHABILITATION	69.01	0	34.12
34.13	MISC REVENUE	B	-27,205	RENAL DIALYSIS	74.00	0	34.13
34.14	MISC REVENUE	B	-12,416	CLINIC	90.00	0	34.14
34.15	MISC REVENUE	B	-12,268	EMERGENCY	91.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	ADVERTISEMENTS	A	-7,263	ADMINISTRATIVE & GENERAL	5.00	0	34.18
34.19	ADVERTISEMENTS	A	-233	RADIOLOGY-DIAGNOSTIC	54.00	0	34.19
45.00	ADVERTISEMENTS	A	-294	RESPIRATORY THERAPY	65.00	0	45.00
45.01	ADVERTISEMENTS	A	-223	ELECTROENCEPHALOGRAPHY	70.00	0	45.01
45.02	ADVERTISEMENTS	A	-12,948	CLINIC	90.00	0	45.02
45.03	GIFTS	A	-17,775	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	GIFTS	A	-324	NURSING ADMINISTRATION	13.00	0	45.04
45.05	GIFTS	A	-94	ADULTS & PEDIATRICS	30.00	0	45.05
45.06	GIFTS	A	-228	OPERATING ROOM	50.00	0	45.06
45.07	GIFTS	A	-10	DELIVERY ROOM & LABOR ROOM	52.00	0	45.07
45.08	GIFTS	A	-430	RADIOLOGY-THERAPEUTIC	55.00	0	45.08
45.09	GIFTS	A	-216	CLINIC	90.00	0	45.09
45.10	ENTERTAINMENT	A	-2,615	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	ENTERTAINMENT	A	-112	NURSING ADMINISTRATION	13.00	0	45.11
45.12	ENTERTAINMENT	A	-34	ADULTS & PEDIATRICS	30.00	0	45.12
45.13	ENTERTAINMENT	A	-31	INTENSIVE CARE UNIT	31.00	0	45.13
45.14	ENTERTAINMENT	A	-186	ELECTROCARDIOLOGY	69.00	0	45.14
45.15	LOBBY EXPENSE	A	-25,392	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	WSI RENT	A	-49,593	PHYSICAL THERAPY	66.00	0	45.16
45.17	INTEREST REVENUE	A	-75,894	CAP REL COSTS-BLDG & FIXT	1.00	9	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
45.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.20
45.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.22
45.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.23
45.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.24
45.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.25
45.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.26
45.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.27
45.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.28
45.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.29
45.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.30
45.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.31

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 2:13 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	
45.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.32
45.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.33
45.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.34
45.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.35
45.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.36
45.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.37
45.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.38
45.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.39
45.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.40
45.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.41
45.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.42
45.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.43
45.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.44
45.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.45
45.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.46
45.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.47
45.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.48
45.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.49
45.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.50
45.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.51
45.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.52
45.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.53
45.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.54
45.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.55
45.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.56
45.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.57
45.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.58
45.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.59
45.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.60
45.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.61
45.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.62
45.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.63
45.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.64
45.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.65
45.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.66

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
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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	
45.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.67
45.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.68
45.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.69
45.70	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.70
45.71	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.71
45.72	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.72
45.73	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.73
45.74	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.74
45.75	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.75
45.76	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.76
45.77	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.77
45.78	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.78
45.79	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.79
45.80	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.80
45.81	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.81
45.82	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.82
45.83	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.83
45.84	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.84
45.85	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.85
45.86	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.86
45.87	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.87
45.88	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.88
45.89	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.89
45.90	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.90
45.91	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.91
45.92	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.92
45.93	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.93
45.94	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.94
45.95	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.95
45.96	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.96
45.97	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.97
45.98	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.98
45.99	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.99
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,624,845				50.00

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

(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

Period:
From 01/01/2019
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Worksheet A-8

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 2:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	114,095	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	512,283	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	480,687
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	14,926,698	14,767,610
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,133,246	11,563,925
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	410,903
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-148,749	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				22,537,573	27,223,125

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

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

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	SSM HEALTH	100.00	FRAN SISTERS	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:			CHURCH		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: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

1.00	114,095	9		1.00
2.00	512,283	9		2.00
3.00	-480,687	11		3.00
4.00	159,088	0		4.00
4.01	-4,430,679	0		4.01
4.02	-410,903	0		4.02
4.03	-148,749	0		4.03
5.00	-4,685,552			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	SSM HOSPITALS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0034

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

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 2:13 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	142,756	0	142,756	211,500	1,084	1.00
2.00	30.00	ADULTS & PEDIATRICS	567,767	567,767	0	179,000	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	9,338	9,338	0	211,500	0	3.00
4.00	40.00	SUBPROVIDER - IPF	51,902	51,902	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	33,714	33,714	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,640,802	2,640,802	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	557,282	479,897	77,385	271,900	320	7.00
8.00	56.00	RADIOISOTOPE	22,560	22,560	0	271,900	0	8.00
9.00	60.00	LABORATORY	390,193	63,545	326,648	260,300	3,286	9.00
10.00	65.00	RESPIRATORY THERAPY	51,162	40,962	10,200	197,500	102	10.00
11.00	69.00	ELECTROCARDIOLOGY	340,165	340,165	0	197,500	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	168,656	158,456	10,200	197,500	102	12.00
13.00	90.00	CLINIC	862,312	802,445	59,867	179,000	461	13.00
14.00	91.00	EMERGENCY	1,387,076	1,338,776	48,300	179,000	216	14.00
200.00			7,225,685	6,550,329	675,356		5,571	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	110,224	5,511	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	41,831	2,092	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	411,224	20,561	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	9,685	484	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	9,685	484	0	0	0	12.00
13.00	90.00	CLINIC	39,673	1,984	0	0	0	13.00
14.00	91.00	EMERGENCY	18,588	929	0	0	0	14.00
200.00			640,910	32,045	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	110,224	32,532	32,532		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	567,767		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	9,338		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	51,902		4.00
5.00	50.00	OPERATING ROOM	0	0	0	33,714		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,640,802		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	41,831	35,554	515,451		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	22,560		8.00
9.00	60.00	LABORATORY	0	411,224	0	63,545		9.00
10.00	65.00	RESPIRATORY THERAPY	0	9,685	515	41,477		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	340,165		11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	9,685	515	158,971		12.00
13.00	90.00	CLINIC	0	39,673	20,194	822,639		13.00
14.00	91.00	EMERGENCY	0	18,588	29,712	1,368,488		14.00
200.00			0	640,910	119,022	6,669,351		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,129,315	4,129,315				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,323,164		2,323,164			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,972,754	22,523	12,671	16,007,948		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,040,193	1,246,355	701,202	1,146,360	17,134,110	5.00
7.00	00700	OPERATION OF PLANT	3,444,119	311,945	175,501	370,606	4,302,171	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	395,255	85,666	48,196	46,197	575,314	8.00
9.00	00900	HOUSEKEEPING	1,092,813	54,407	30,610	486,776	1,664,606	9.00
10.00	01000	DIETARY	372,175	30,528	17,175	121,447	541,325	10.00
11.00	01100	CAFETERIA	636,747	78,268	44,034	290,518	1,049,567	11.00
13.00	01300	NURSING ADMINISTRATION	1,025,635	7,697	4,330	452,538	1,490,200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	490,921	5,051	2,842	151,195	650,009	14.00
15.00	01500	PHARMACY	1,372,759	0	0	577,564	1,950,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,737	46,518	26,171	80,493	430,919	16.00
17.00	01700	SOCIAL SERVICE	995,983	19,338	10,880	352,191	1,378,392	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,582,258	526,610	296,273	3,306,669	10,711,810	30.00
31.00	03100	INTENSIVE CARE UNIT	1,549,875	55,793	31,389	607,281	2,244,338	31.00
40.00	04000	SUBPROVIDER - IPF	2,050,232	68,926	38,778	1,010,090	3,168,026	40.00
43.00	04300	NURSERY	553,209	37,426	21,056	219,183	830,874	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,296,760	439,674	247,362	901,587	3,885,383	50.00
51.00	05100	RECOVERY ROOM	282,673	0	0	130,383	413,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85,532	63,518	35,736	102,381	287,167	52.00
53.00	05300	ANESTHESIOLOGY	76,140	4,002	2,252	4,389	86,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,082,048	123,968	69,745	517,894	1,793,655	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	724,860	0	0	205,324	930,184	55.00
56.00	05600	RADIOISOTOPE	423,204	9,082	5,110	81,767	519,163	56.00
57.00	05700	CT SCAN	340,594	2,251	1,267	164,842	508,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162,443	3,925	2,208	66,755	235,331	58.00
59.00	05900	CARDIAC CATHETERIZATION	124,584	23,976	13,489	52,125	214,174	59.00
60.00	06000	LABORATORY	3,459,617	57,197	32,179	781,697	4,330,690	60.00
64.00	06400	INTRAVENOUS THERAPY	278,275	10,208	5,743	135,139	429,365	64.00
65.00	06500	RESPIRATORY THERAPY	1,079,397	12,036	6,771	496,792	1,594,996	65.00
66.00	06600	PHYSICAL THERAPY	1,227,902	45,806	25,771	606,728	1,906,207	66.00
66.01	03340	CLINICAL NUTRITION	171,566	0	0	85,838	257,404	66.01
67.00	06700	OCCUPATIONAL THERAPY	131,844	0	0	64,985	196,829	67.00
68.00	06800	SPEECH PATHOLOGY	107,029	6,956	3,913	54,485	172,383	68.00
69.00	06900	ELECTROCARDIOLOGY	828,846	57,717	32,472	416,567	1,335,602	69.00
69.01	03140	CARDIAC REHABILITATION	85,464	0	0	47,978	133,442	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	109,714	21,215	11,935	51,316	194,180	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,023,795	0	0	0	3,023,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	543,744	0	0	0	543,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,340,555	0	0	0	4,340,555	73.00
74.00	07400	RENAL DIALYSIS	118,857	0	0	0	118,857	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,740,393	106,207	59,752	744,036	2,650,388	90.00
91.00	09100	EMERGENCY	2,111,713	104,418	58,746	1,014,895	3,289,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,262,693	3,689,207	2,075,559	15,947,011	81,514,043	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,217	3,156	1,775	16,727	54,875	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,922	0	0	0	50,922	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	202,765	436,952	245,830	44,210	929,757	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	201,525	0	0	0	201,525	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	82,751,122	4,129,315	2,323,164	16,007,948	82,751,122	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,134,110					5.00
7.00	00700	OPERATION OF PLANT	1,123,396	5,425,567				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	150,228	182,378	907,920			8.00
9.00	00900	HOUSEKEEPING	434,667	115,829	0	2,215,102		9.00
10.00	01000	DIETARY	141,352	64,991	0	28,077	775,745	10.00
11.00	01100	CAFETERIA	274,066	166,626	0	71,985	0	11.00
13.00	01300	NURSING ADMINISTRATION	389,125	16,386	0	7,079	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,732	10,753	0	4,646	0	14.00
15.00	01500	PHARMACY	509,274	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,523	99,034	0	42,784	0	16.00
17.00	01700	SOCIAL SERVICE	359,930	41,170	0	17,786	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,797,102	1,121,118	568,265	484,343	485,536	30.00
31.00	03100	INTENSIVE CARE UNIT	586,048	118,779	62,931	51,314	53,770	31.00
40.00	04000	SUBPROVIDER - IPF	827,244	146,738	253,366	63,393	216,481	40.00
43.00	04300	NURSERY	216,960	79,678	23,358	34,422	19,958	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,014,563	936,037	0	404,383	0	50.00
51.00	05100	RECOVERY ROOM	107,858	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	74,986	135,226	0	58,420	0	52.00
53.00	05300	ANESTHESIOLOGY	22,661	8,521	0	3,681	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	468,365	263,919	0	114,017	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	242,892	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	135,565	19,336	0	8,353	0	56.00
57.00	05700	CT SCAN	132,900	4,793	0	2,071	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	61,450	8,357	0	3,610	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,926	51,043	0	22,051	0	59.00
60.00	06000	LABORATORY	1,130,843	121,769	0	52,606	0	60.00
64.00	06400	INTRAVENOUS THERAPY	112,117	21,732	0	9,389	0	64.00
65.00	06500	RESPIRATORY THERAPY	416,490	25,624	0	11,070	0	65.00
66.00	06600	PHYSICAL THERAPY	497,754	97,518	0	42,129	0	66.00
66.01	03340	CLINICAL NUTRITION	67,214	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	51,397	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,013	14,809	0	6,398	0	68.00
69.00	06900	ELECTROCARDIOLOGY	348,756	122,875	0	53,084	0	69.00
69.01	03140	CARDIAC REHABILITATION	34,845	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,705	45,164	0	19,512	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	789,582	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,984	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,133,419	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	31,036	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	692,077	226,108	0	97,682	0	90.00
91.00	09100	EMERGENCY	859,035	222,298	0	96,036	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,811,080	4,488,609	907,920	1,810,321	775,745	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,329	6,718	0	2,902	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,297	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	242,781	930,240	0	401,879	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	52,623	0	0	0	0	194.03
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)	17,134,110	5,425,567	907,920	2,215,102	775,745	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,562,244					11.00
13.00	01300	NURSING ADMINISTRATION	52,190	1,954,980				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,437	0	852,577			14.00
15.00	01500	PHARMACY	66,610	0	8,738	2,534,945		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,283	0	186	0	694,729	16.00
17.00	01700	SOCIAL SERVICE	40,618	56,941	14	2,583	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	381,353	740,236	112,330	172,618	52,455	30.00
31.00	03100	INTENSIVE CARE UNIT	70,037	161,333	45,966	53,779	7,533	31.00
40.00	04000	SUBPROVIDER - IPF	116,492	237,255	4,858	4,323	12,898	40.00
43.00	04300	NURSERY	25,278	37,961	0	0	1,350	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103,979	151,843	445,890	296,256	77,935	50.00
51.00	05100	RECOVERY ROOM	15,037	28,471	2,319	3,137	9,566	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,807	104,392	20,744	15,949	8,647	52.00
53.00	05300	ANESTHESIOLOGY	506	0	33,415	935,669	10,927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,728	9,490	14,260	91,160	30,587	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,680	9,490	1,636	0	14,259	55.00
56.00	05600	RADIOISOTOPE	9,430	0	454	0	15,274	56.00
57.00	05700	CT SCAN	19,011	0	10,900	924,041	80,446	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,699	0	3,520	2,794	15,285	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,011	9,490	0	395	2,093	59.00
60.00	06000	LABORATORY	90,152	0	18,215	9,306	113,076	60.00
64.00	06400	INTRAVENOUS THERAPY	15,585	28,471	9,105	19,244	3,974	64.00
65.00	06500	RESPIRATORY THERAPY	57,294	0	13,231	0	25,900	65.00
66.00	06600	PHYSICAL THERAPY	69,973	0	1,737	185	15,680	66.00
66.01	03340	CLINICAL NUTRITION	9,900	0	0	0	116	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,495	0	30	0	1,598	67.00
68.00	06800	SPEECH PATHOLOGY	6,284	0	101	0	1,006	68.00
69.00	06900	ELECTROCARDIOLOGY	48,042	56,941	4,154	3,506	35,612	69.00
69.01	03140	CARDIAC REHABILITATION	5,533	9,490	171	0	1,250	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,918	0	819	0	2,352	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	68,444	73.00
74.00	07400	RENAL DIALYSIS	0	0	291	0	1,015	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	85,808	66,431	5,764	0	11,910	90.00
91.00	09100	EMERGENCY	117,046	246,745	93,729	0	62,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,555,216	1,954,980	852,577	2,534,945	694,729	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,929	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	5,099	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,562,244	1,954,980	852,577	2,534,945	694,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,897,434					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,187,599	0	18,814,765	0	18,814,765	30.00
31.00	03100	INTENSIVE CARE UNIT	131,518	0	3,587,346	0	3,587,346	31.00
40.00	04000	SUBPROVIDER - IPF	529,502	0	5,580,576	0	5,580,576	40.00
43.00	04300	NURSERY	48,815	0	1,318,654	0	1,318,654	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	7,316,269	0	7,316,269	50.00
51.00	05100	RECOVERY ROOM	0	0	579,444	0	579,444	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	717,338	0	717,338	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,102,163	0	1,102,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,845,181	0	2,845,181	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,222,141	0	1,222,141	55.00
56.00	05600	RADIOISOTOPE	0	0	707,575	0	707,575	56.00
57.00	05700	CT SCAN	0	0	1,683,116	0	1,683,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	338,046	0	338,046	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	361,183	0	361,183	59.00
60.00	06000	LABORATORY	0	0	5,866,657	0	5,866,657	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	648,982	0	648,982	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,144,605	0	2,144,605	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,631,183	0	2,631,183	66.00
66.01	03340	CLINICAL NUTRITION	0	0	334,634	0	334,634	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	257,349	0	257,349	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	245,994	0	245,994	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,008,572	0	2,008,572	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	184,731	0	184,731	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	318,650	0	318,650	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,821,569	0	3,821,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	688,863	0	688,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,542,418	0	5,542,418	73.00
74.00	07400	RENAL DIALYSIS	0	0	151,199	0	151,199	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	3,836,168	0	3,836,168	90.00
91.00	09100	EMERGENCY	0	0	4,986,875	0	4,986,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,897,434	0	79,842,246	0	79,842,246	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	80,753	0	80,753	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	64,219	0	64,219	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	2,509,756	0	2,509,756	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	254,148	0	254,148	194.03
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)	1,897,434	0	82,751,122	0	82,751,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	22,523	12,671	35,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,385	1,246,355	701,202	1,948,942	5.00
7.00	00700	OPERATION OF PLANT	556	311,945	175,501	488,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,666	48,196	133,862	8.00
9.00	00900	HOUSEKEEPING	56,499	54,407	30,610	141,516	9.00
10.00	01000	DIETARY	0	30,528	17,175	47,703	10.00
11.00	01100	CAFETERIA	0	78,268	44,034	122,302	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,697	4,330	12,027	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,380	5,051	2,842	33,273	14.00
15.00	01500	PHARMACY	106,908	0	0	106,908	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,518	26,171	72,689	16.00
17.00	01700	SOCIAL SERVICE	0	19,338	10,880	30,218	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,994	526,610	296,273	833,877	30.00
31.00	03100	INTENSIVE CARE UNIT	1,933	55,793	31,389	89,115	31.00
40.00	04000	SUBPROVIDER - IPF	0	68,926	38,778	107,704	40.00
43.00	04300	NURSERY	0	37,426	21,056	58,482	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,252	439,674	247,362	688,288	50.00
51.00	05100	RECOVERY ROOM	0	0	0	287	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	63,518	35,736	99,254	52.00
53.00	05300	ANESTHESIOLOGY	0	4,002	2,252	6,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,968	69,745	193,713	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,940	0	0	13,940	55.00
56.00	05600	RADIOISOTOPE	0	9,082	5,110	14,192	56.00
57.00	05700	CT SCAN	0	2,251	1,267	3,518	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	695	3,925	2,208	6,828	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	23,976	13,489	37,465	59.00
60.00	06000	LABORATORY	44,215	57,197	32,179	133,591	60.00
64.00	06400	INTRAVENOUS THERAPY	0	10,208	5,743	15,951	64.00
65.00	06500	RESPIRATORY THERAPY	15,144	12,036	6,771	33,951	65.00
66.00	06600	PHYSICAL THERAPY	77,398	45,806	25,771	148,975	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	189	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	143	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,956	3,913	10,869	68.00
69.00	06900	ELECTROCARDIOLOGY	14,064	57,717	32,472	104,253	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	105	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,215	11,935	33,150	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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	21,455	106,207	59,752	187,414	90.00
91.00	09100	EMERGENCY	7,643	104,418	58,746	170,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,461	3,689,207	2,075,559	6,164,227	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,156	1,775	4,931	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-49,593	0	0	-49,593	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	436,952	245,830	682,782	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	349,868	4,129,315	2,323,164	6,802,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,951,462					5.00
7.00	00700	OPERATION OF PLANT	127,947	616,764				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,110	20,732	171,806			8.00
9.00	00900	HOUSEKEEPING	49,505	13,167	0	205,258		9.00
10.00	01000	DIETARY	16,099	7,388	0	2,602	74,059	10.00
11.00	01100	CAFETERIA	31,214	18,942	0	6,670	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,319	1,863	0	656	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,331	1,222	0	430	0	14.00
15.00	01500	PHARMACY	58,003	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,816	11,258	0	3,965	0	16.00
17.00	01700	SOCIAL SERVICE	40,993	4,680	0	1,648	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	318,579	127,447	107,532	44,880	46,354	30.00
31.00	03100	INTENSIVE CARE UNIT	66,747	13,502	11,909	4,755	5,133	31.00
40.00	04000	SUBPROVIDER - IPF	94,217	16,681	47,945	5,874	20,667	40.00
43.00	04300	NURSERY	24,710	9,058	4,420	3,190	1,905	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,551	106,406	0	37,471	0	50.00
51.00	05100	RECOVERY ROOM	12,284	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,540	15,372	0	5,413	0	52.00
53.00	05300	ANESTHESIOLOGY	2,581	969	0	341	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,343	30,002	0	10,565	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,664	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	15,440	2,198	0	774	0	56.00
57.00	05700	CT SCAN	15,136	545	0	192	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,999	950	0	335	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,370	5,802	0	2,043	0	59.00
60.00	06000	LABORATORY	128,795	13,842	0	4,875	0	60.00
64.00	06400	INTRAVENOUS THERAPY	12,769	2,470	0	870	0	64.00
65.00	06500	RESPIRATORY THERAPY	47,435	2,913	0	1,026	0	65.00
66.00	06600	PHYSICAL THERAPY	56,691	11,086	0	3,904	0	66.00
66.01	03340	CLINICAL NUTRITION	7,655	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,854	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,127	1,683	0	593	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,721	13,968	0	4,919	0	69.00
69.01	03140	CARDIAC REHABILITATION	3,969	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,775	5,134	0	1,808	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,928	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,171	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,088	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,535	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	78,823	25,703	0	9,052	0	90.00
91.00	09100	EMERGENCY	97,838	25,270	0	8,899	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,914,672	510,253	171,806	167,750	74,059	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,632	764	0	269	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,514	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	27,651	105,747	0	37,239	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	5,993	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,951,462	616,764	171,806	205,258	74,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	179,767					11.00
13.00	01300	NURSING ADMINISTRATION	6,006	65,866				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,007	0	56,595			14.00
15.00	01500	PHARMACY	7,665	0	580	174,426		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068	0	12	0	101,985	16.00
17.00	01700	SOCIAL SERVICE	4,674	1,918	1	178	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,879	24,940	7,457	11,878	7,696	30.00
31.00	03100	INTENSIVE CARE UNIT	8,059	5,436	3,051	3,700	1,105	31.00
40.00	04000	SUBPROVIDER - IPF	13,405	7,993	323	297	1,892	40.00
43.00	04300	NURSERY	2,909	1,279	0	0	198	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,965	5,116	29,598	20,385	11,434	50.00
51.00	05100	RECOVERY ROOM	1,730	959	154	216	1,403	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,359	3,517	1,377	1,097	1,269	52.00
53.00	05300	ANESTHESIOLOGY	58	0	2,218	64,383	1,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,873	320	947	6,273	4,487	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,725	320	109	0	2,092	55.00
56.00	05600	RADIOISOTOPE	1,085	0	30	0	2,241	56.00
57.00	05700	CT SCAN	2,188	0	724	63,582	11,802	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	886	0	234	192	2,242	58.00
59.00	05900	CARDIAC CATHETERIZATION	692	320	0	27	307	59.00
60.00	06000	LABORATORY	10,374	0	1,209	640	16,653	60.00
64.00	06400	INTRAVENOUS THERAPY	1,793	959	604	1,324	583	64.00
65.00	06500	RESPIRATORY THERAPY	6,593	0	878	0	3,800	65.00
66.00	06600	PHYSICAL THERAPY	8,052	0	115	13	2,300	66.00
66.01	03340	CLINICAL NUTRITION	1,139	0	0	0	17	66.01
67.00	06700	OCCUPATIONAL THERAPY	862	0	2	0	234	67.00
68.00	06800	SPEECH PATHOLOGY	723	0	7	0	148	68.00
69.00	06900	ELECTROCARDIOLOGY	5,528	1,918	276	241	5,225	69.00
69.01	03140	CARDIAC REHABILITATION	637	320	11	0	183	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	681	0	54	0	345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	460	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,041	73.00
74.00	07400	RENAL DIALYSIS	0	0	19	0	149	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,874	2,238	383	0	1,747	90.00
91.00	09100	EMERGENCY	13,469	8,313	6,222	0	9,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,958	65,866	56,595	174,426	101,985	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	222	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	587	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	179,767	65,866	56,595	174,426	101,985	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	85,084					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,254		1,635,041	0	1,635,041	30.00
31.00	03100	INTENSIVE CARE UNIT	5,897		219,744	0	219,744	31.00
40.00	04000	SUBPROVIDER - IPF	23,744		342,963	0	342,963	40.00
43.00	04300	NURSERY	2,189		108,822	0	108,822	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		1,028,196	0	1,028,196	50.00
51.00	05100	RECOVERY ROOM	0		17,033	0	17,033	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		137,423	0	137,423	52.00
53.00	05300	ANESTHESIOLOGY	0		78,417	0	78,417	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		307,662	0	307,662	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		47,301	0	47,301	55.00
56.00	05600	RADIOISOTOPE	0		36,140	0	36,140	56.00
57.00	05700	CT SCAN	0		98,049	0	98,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		18,813	0	18,813	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		53,141	0	53,141	59.00
60.00	06000	LABORATORY	0		311,698	0	311,698	60.00
64.00	06400	INTRAVENOUS THERAPY	0		37,620	0	37,620	64.00
65.00	06500	RESPIRATORY THERAPY	0		97,688	0	97,688	65.00
66.00	06600	PHYSICAL THERAPY	0		232,470	0	232,470	66.00
66.01	03340	CLINICAL NUTRITION	0		9,000	0	9,000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0		7,095	0	7,095	67.00
68.00	06800	SPEECH PATHOLOGY	0		19,270	0	19,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0		176,965	0	176,965	69.00
69.01	03140	CARDIAC REHABILITATION	0		5,225	0	5,225	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		47,060	0	47,060	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		91,130	0	91,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		16,631	0	16,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		139,129	0	139,129	73.00
74.00	07400	RENAL DIALYSIS	0		3,703	0	3,703	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		316,870	0	316,870	90.00
91.00	09100	EMERGENCY	0		342,176	0	342,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0		0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,084	0	5,982,475	0	5,982,475	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		7,855	0	7,855	190.00
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		-48,079	0	-48,079	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0		854,103	0	854,103	194.00
194.01	07951	NON-REIMBURSABLE	0		0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0		0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0		5,993	0	5,993	194.03
200.00		Cross Foot Adjustments		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)	85,084	0	6,802,347	0	6,802,347	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	429,194					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		429,194				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	2,341	31,908,082			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	129,544	129,544	2,285,002	-17,134,110	65,617,012	5.00
7.00	00700	OPERATION OF PLANT	32,423	32,423	738,717	0	4,302,171	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	8,904	92,083	0	575,314	8.00
9.00	00900	HOUSEKEEPING	5,655	5,655	970,274	0	1,664,606	9.00
10.00	01000	DIETARY	3,173	3,173	242,077	0	541,325	10.00
11.00	01100	CAFETERIA	8,135	8,135	579,080	0	1,049,567	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	902,029	0	1,490,200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	525	301,371	0	650,009	14.00
15.00	01500	PHARMACY	0	0	1,151,239	0	1,950,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	4,835	160,445	0	430,919	16.00
17.00	01700	SOCIAL SERVICE	2,010	2,010	702,011	0	1,378,392	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,735	54,735	6,591,039	0	10,711,810	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	5,799	1,210,474	0	2,244,338	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	7,164	2,013,379	0	3,168,026	40.00
43.00	04300	NURSERY	3,890	3,890	436,891	0	830,874	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,699	45,699	1,797,103	0	3,885,383	50.00
51.00	05100	RECOVERY ROOM	0	0	259,889	0	413,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	6,602	204,072	0	287,167	52.00
53.00	05300	ANESTHESIOLOGY	416	416	8,749	0	86,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	12,885	1,032,301	0	1,793,655	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	409,266	0	930,184	55.00
56.00	05600	RADIOISOTOPE	944	944	162,984	0	519,163	56.00
57.00	05700	CT SCAN	234	234	328,574	0	508,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	408	133,060	0	235,331	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	2,492	103,899	0	214,174	59.00
60.00	06000	LABORATORY	5,945	5,945	1,558,130	0	4,330,690	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	1,061	269,368	0	429,365	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	1,251	990,239	0	1,594,996	65.00
66.00	06600	PHYSICAL THERAPY	4,761	4,761	1,209,370	0	1,906,207	66.00
66.01	03340	CLINICAL NUTRITION	0	0	171,099	0	257,404	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	129,533	0	196,829	67.00
68.00	06800	SPEECH PATHOLOGY	723	723	108,603	0	172,383	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	5,999	830,330	0	1,335,602	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	95,633	0	133,442	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	2,205	102,287	0	194,180	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,023,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	543,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,340,555	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	118,857	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,039	11,039	1,483,062	0	2,650,388	90.00
91.00	09100	EMERGENCY	10,853	10,853	2,022,957	0	3,289,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,450	383,450	31,786,619	-17,134,110	64,379,933	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	328	33,341	0	54,875	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	50,922	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	45,416	88,122	0	929,757	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	201,525	194.03
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)	4,129,315	2,323,164	16,007,948		17,134,110	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.621092	5.412853	0.501689		0.261123	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			35,194		1,951,462	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001103		0.029740	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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	264,886				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	18,813			8.00
9.00	00900	HOUSEKEEPING	5,655	0	250,327		9.00
10.00	01000	DIETARY	3,173	0	3,173	18,813	10.00
11.00	01100	CAFETERIA	8,135	0	8,135	0	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	0	525	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	0	4,835	0	16.00
17.00	01700	SOCIAL SERVICE	2,010	0	2,010	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,735	11,775	54,735	11,775	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	1,304	5,799	1,304	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	5,250	7,164	5,250	40.00
43.00	04300	NURSERY	3,890	484	3,890	484	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,699	0	45,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	0	6,602	0	52.00
53.00	05300	ANESTHESIOLOGY	416	0	416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	0	12,885	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	944	0	944	0	56.00
57.00	05700	CT SCAN	234	0	234	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	0	408	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	0	2,492	0	59.00
60.00	06000	LABORATORY	5,945	0	5,945	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	0	1,061	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	0	1,251	0	65.00
66.00	06600	PHYSICAL THERAPY	4,761	0	4,761	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	723	0	723	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	0	5,999	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	0	2,205	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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,039	0	11,039	0	90.00
91.00	09100	EMERGENCY	10,853	0	10,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,142	18,813	204,583	18,813	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	0	328	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	0	45,416	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
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)	5,425,567	907,920	2,215,102	775,745	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.482649	48.260246	8.848834	41.234519	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	616,764	171,806	205,258	74,059	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.328413	9.132302	0.819959	3.936586	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	206					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,206,226				14.00
15.00	01500	PHARMACY	0	32,861	96,159			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	699	0	306,971,671		16.00
17.00	01700	SOCIAL SERVICE	6	51	98	0	18,813	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	78	422,433	6,548	23,179,418	11,775	30.00
31.00	03100	INTENSIVE CARE UNIT	17	172,860	2,040	3,328,558	1,304	31.00
40.00	04000	SUBPROVIDER - IPF	25	18,270	164	5,699,538	5,250	40.00
43.00	04300	NURSERY	4	0	0	596,590	484	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16	1,676,826	11,238	34,438,722	0	50.00
51.00	05100	RECOVERY ROOM	3	8,721	119	4,227,115	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11	78,009	605	3,820,895	0	52.00
53.00	05300	ANESTHESIOLOGY	0	125,662	35,493	4,828,530	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1	53,626	3,458	13,515,940	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1	6,154	0	6,300,895	0	55.00
56.00	05600	RADIOISOTOPE	0	1,709	0	6,749,575	0	56.00
57.00	05700	CT SCAN	0	40,990	35,052	35,548,316	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,236	106	6,754,506	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1	0	15	925,050	0	59.00
60.00	06000	LABORATORY	0	68,501	353	49,943,804	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3	34,240	730	1,756,172	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	49,758	0	11,444,790	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,532	7	6,928,668	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	51,405	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	113	0	706,255	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	381	0	444,601	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6	15,621	133	15,736,645	0	69.00
69.01	03140	CARDIAC REHABILITATION	1	642	0	552,535	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,079	0	1,039,325	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,620,061	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,385,463	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,245,014	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,093	0	448,450	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7	21,678	0	5,263,003	0	90.00
91.00	09100	EMERGENCY	26	352,481	0	27,491,832	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206	3,206,226	96,159	306,971,671	18,813	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,954,980	852,577	2,534,945	694,729	1,897,434	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9,490.194175	0.265913	26.362015	0.002263	100.857598	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,866	56,595	174,426	101,985	85,084	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	319.737864	0.017652	1.813933	0.000332	4.522617	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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	03340	CLINICAL NUTRITION	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03140	CARDIAC REHABILITATION	69.01
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			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.30	09930	OOT	99.30
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	192.01
194.00	07950	NON-REIMBURSABLE	194.00
194.01	07951	NON-REIMBURSABLE	194.01
194.02	07952	NON-REIMBURSABLE	194.02
194.03	07953	CONTRACT PHARMACY	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/27/2020 2:13 pm	
					Title XVIII	Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,814,765		18,814,765	0	18,814,765	30.00
31.00	03100	INTENSIVE CARE UNIT	3,587,346		3,587,346	0	3,587,346	31.00
40.00	04000	SUBPROVIDER - IPF	5,580,576		5,580,576	0	5,580,576	40.00
43.00	04300	NURSERY	1,318,654		1,318,654	0	1,318,654	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,316,269		7,316,269	0	7,316,269	50.00
51.00	05100	RECOVERY ROOM	579,444		579,444	0	579,444	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	717,338		717,338	0	717,338	52.00
53.00	05300	ANESTHESIOLOGY	1,102,163		1,102,163	0	1,102,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,845,181		2,845,181	0	2,845,181	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,222,141		1,222,141	35,554	1,257,695	55.00
56.00	05600	RADIOISOTOPE	707,575		707,575	0	707,575	56.00
57.00	05700	CT SCAN	1,683,116		1,683,116	0	1,683,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338,046		338,046	0	338,046	58.00
59.00	05900	CARDIAC CATHETERIZATION	361,183		361,183	0	361,183	59.00
60.00	06000	LABORATORY	5,866,657		5,866,657	0	5,866,657	60.00
64.00	06400	INTRAVENOUS THERAPY	648,982		648,982	0	648,982	64.00
65.00	06500	RESPIRATORY THERAPY	2,144,605	0	2,144,605	515	2,145,120	65.00
66.00	06600	PHYSICAL THERAPY	2,631,183	0	2,631,183	0	2,631,183	66.00
66.01	03340	CLINICAL NUTRITION	334,634	0	334,634	0	334,634	66.01
67.00	06700	OCCUPATIONAL THERAPY	257,349	0	257,349	0	257,349	67.00
68.00	06800	SPEECH PATHOLOGY	245,994	0	245,994	0	245,994	68.00
69.00	06900	ELECTROCARDIOLOGY	2,008,572		2,008,572	0	2,008,572	69.00
69.01	03140	CARDIAC REHABILITATION	184,731		184,731	0	184,731	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	318,650		318,650	515	319,165	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,821,569		3,821,569	0	3,821,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	688,863		688,863	0	688,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,542,418		5,542,418	0	5,542,418	73.00
74.00	07400	RENAL DIALYSIS	151,199		151,199	0	151,199	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,836,168		3,836,168	20,194	3,856,362	90.00
91.00	09100	EMERGENCY	4,986,875		4,986,875	29,712	5,016,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,218,584		3,218,584		3,218,584	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0		0		0	99.30
200.00		Subtotal (see instructions)	83,060,830	0	83,060,830	86,490	83,147,320	200.00
201.00		Less Observation Beds	3,218,584		3,218,584		3,218,584	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0034		Period: From 01/01/2019 To 12/31/2019		Worksheet C Part I Date/Time Prepared: 8/27/2020 2:13 pm		
				Title XVIII			Hospital		PPS	
Cost Center Description				Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
				Inpatient	Outpatient	Total (col. 6 + col. 7)				
				6.00	7.00	8.00				
9.00				10.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	20,586,952		20,586,952					30.00
31.00	03100	INTENSIVE CARE UNIT	3,328,558		3,328,558					31.00
40.00	04000	SUBPROVIDER - IPF	5,699,538		5,699,538					40.00
43.00	04300	NURSERY	596,590		596,590					43.00
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	10,315,090	24,123,632	34,438,722	0.212443	0.000000			50.00
51.00	05100	RECOVERY ROOM	1,606,800	2,620,315	4,227,115	0.137078	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,674,640	1,146,255	3,820,895	0.187741	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	2,317,100	2,511,430	4,828,530	0.228261	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,491,468	11,024,472	13,515,940	0.210506	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	82,535	6,218,360	6,300,895	0.193963	0.000000			55.00
56.00	05600	RADIOISOTOPE	483,535	6,266,040	6,749,575	0.104833	0.000000			56.00
57.00	05700	CT SCAN	7,616,067	27,932,249	35,548,316	0.047347	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	751,690	6,002,816	6,754,506	0.050047	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	318,625	606,425	925,050	0.390447	0.000000			59.00
60.00	06000	LABORATORY	17,991,974	31,951,830	49,943,804	0.117465	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	8,970	1,747,202	1,756,172	0.369544	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	6,273,512	5,171,278	11,444,790	0.187387	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	1,117,808	5,810,860	6,928,668	0.379753	0.000000			66.00
66.01	03340	CLINICAL NUTRITION	0	51,405	51,405	6.509756	0.000000			66.01
67.00	06700	OCCUPATIONAL THERAPY	147,309	558,946	706,255	0.364385	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	108,701	335,900	444,601	0.553292	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	5,152,291	10,584,354	15,736,645	0.127637	0.000000			69.00
69.01	03140	CARDIAC REHABILITATION	0	552,535	552,535	0.334334	0.000000			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	209,645	829,680	1,039,325	0.306593	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,006,627	613,434	3,620,061	1.055664	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	952,397	433,066	1,385,463	0.497208	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,208,043	17,036,971	30,245,014	0.183251	0.000000			73.00
74.00	07400	RENAL DIALYSIS	405,560	42,890	448,450	0.337159	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	6,350	5,256,653	5,263,003	0.728893	0.000000			90.00
91.00	09100	EMERGENCY	6,651,138	20,840,694	27,491,832	0.181395	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,939	2,210,527	2,592,466	1.241514	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS										
99.30	09930	OOT	0	0	0					99.30
200.00		Subtotal (see instructions)	114,491,452	192,480,219	306,971,671					200.00
201.00		Less Observation Beds								201.00
202.00		Total (see instructions)	114,491,452	192,480,219	306,971,671					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.212443		50.00
51.00	05100	RECOVERY ROOM	0.137078		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.187741		52.00
53.00	05300	ANESTHESIOLOGY	0.228261		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210506		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.199606		55.00
56.00	05600	RADIOISOTOPE	0.104833		56.00
57.00	05700	CT SCAN	0.047347		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050047		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.390447		59.00
60.00	06000	LABORATORY	0.117465		60.00
64.00	06400	INTRAVENOUS THERAPY	0.369544		64.00
65.00	06500	RESPIRATORY THERAPY	0.187432		65.00
66.00	06600	PHYSICAL THERAPY	0.379753		66.00
66.01	03340	CLINICAL NUTRITION	6.509756		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.364385		67.00
68.00	06800	SPEECH PATHOLOGY	0.553292		68.00
69.00	06900	ELECTROCARDIOLOGY	0.127637		69.00
69.01	03140	CARDIAC REHABILITATION	0.334334		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.307089		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497208		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183251		73.00
74.00	07400	RENAL DIALYSIS	0.337159		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.732730		90.00
91.00	09100	EMERGENCY	0.182476		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.241514		92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT			99.30
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

MCRIF32 - 16.2.168.1

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0034		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/27/2020 2:13 pm		
				Title XIX			Hospital	PPS	
Cost Center Description				Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
				Inpatient	Outpatient	Total (col. 6 + col. 7)			
				6.00	7.00	8.00			
9.00				10.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	20,586,952		20,586,952				30.00
31.00	03100	INTENSIVE CARE UNIT	3,328,558		3,328,558				31.00
40.00	04000	SUBPROVIDER - IPF	5,699,538		5,699,538				40.00
43.00	04300	NURSERY	596,590		596,590				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	10,315,090	24,123,632	34,438,722	0.212443	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,606,800	2,620,315	4,227,115	0.137078	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,674,640	1,146,255	3,820,895	0.187741	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,317,100	2,511,430	4,828,530	0.228261	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,491,468	11,024,472	13,515,940	0.210506	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	82,535	6,218,360	6,300,895	0.193963	0.000000		55.00
56.00	05600	RADIOISOTOPE	483,535	6,266,040	6,749,575	0.104833	0.000000		56.00
57.00	05700	CT SCAN	7,616,067	27,932,249	35,548,316	0.047347	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	751,690	6,002,816	6,754,506	0.050047	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	318,625	606,425	925,050	0.390447	0.000000		59.00
60.00	06000	LABORATORY	17,991,974	31,951,830	49,943,804	0.117465	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	8,970	1,747,202	1,756,172	0.369544	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	6,273,512	5,171,278	11,444,790	0.187387	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,117,808	5,810,860	6,928,668	0.379753	0.000000		66.00
66.01	03340	CLINICAL NUTRITION	0	51,405	51,405	6.509756	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	147,309	558,946	706,255	0.364385	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	108,701	335,900	444,601	0.553292	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	5,152,291	10,584,354	15,736,645	0.127637	0.000000		69.00
69.01	03140	CARDIAC REHABILITATION	0	552,535	552,535	0.334334	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	209,645	829,680	1,039,325	0.306593	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,006,627	613,434	3,620,061	1.055664	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	952,397	433,066	1,385,463	0.497208	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,208,043	17,036,971	30,245,014	0.183251	0.000000		73.00
74.00	07400	RENAL DIALYSIS	405,560	42,890	448,450	0.337159	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	6,350	5,256,653	5,263,003	0.728893	0.000000		90.00
91.00	09100	EMERGENCY	6,651,138	20,840,694	27,491,832	0.181395	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,939	2,210,527	2,592,466	1.241514	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.30	09930	OOT	0	0	0				99.30
200.00		Subtotal (see instructions)	114,491,452	192,480,219	306,971,671				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	114,491,452	192,480,219	306,971,671				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212443			50.00
51.00	05100	RECOVERY ROOM	0.137078			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.187741			52.00
53.00	05300	ANESTHESIOLOGY	0.228261			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210506			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.199606			55.00
56.00	05600	RADIOISOTOPE	0.104833			56.00
57.00	05700	CT SCAN	0.047347			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050047			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.390447			59.00
60.00	06000	LABORATORY	0.117465			60.00
64.00	06400	INTRAVENOUS THERAPY	0.369544			64.00
65.00	06500	RESPIRATORY THERAPY	0.187432			65.00
66.00	06600	PHYSICAL THERAPY	0.379753			66.00
66.01	03340	CLINICAL NUTRITION	6.509756			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.364385			67.00
68.00	06800	SPEECH PATHOLOGY	0.553292			68.00
69.00	06900	ELECTROCARDIOLOGY	0.127637			69.00
69.01	03140	CARDIAC REHABILITATION	0.334334			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.307089			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497208			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183251			73.00
74.00	07400	RENAL DIALYSIS	0.337159			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.732730			90.00
91.00	09100	EMERGENCY	0.182476			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.241514			92.00
OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT				99.30
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,316,269	1,028,196	6,288,073	0	0
51.00	05100	RECOVERY ROOM	579,444	17,033	562,411	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	717,338	137,423	579,915	0	0
53.00	05300	ANESTHESIOLOGY	1,102,163	78,417	1,023,746	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,845,181	307,662	2,537,519	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	1,222,141	47,301	1,174,840	0	0
56.00	05600	RADIOISOTOPE	707,575	36,140	671,435	0	0
57.00	05700	CT SCAN	1,683,116	98,049	1,585,067	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338,046	18,813	319,233	0	0
59.00	05900	CARDIAC CATHETERIZATION	361,183	53,141	308,042	0	0
60.00	06000	LABORATORY	5,866,657	311,698	5,554,959	0	0
64.00	06400	INTRAVENOUS THERAPY	648,982	37,620	611,362	0	0
65.00	06500	RESPIRATORY THERAPY	2,144,605	97,688	2,046,917	0	0
66.00	06600	PHYSICAL THERAPY	2,631,183	232,470	2,398,713	0	0
66.01	03340	CLINICAL NUTRITION	334,634	9,000	325,634	0	0
67.00	06700	OCCUPATIONAL THERAPY	257,349	7,095	250,254	0	0
68.00	06800	SPEECH PATHOLOGY	245,994	19,270	226,724	0	0
69.00	06900	ELECTROCARDIOLOGY	2,008,572	176,965	1,831,607	0	0
69.01	03140	CARDIAC REHABILITATION	184,731	5,225	179,506	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	318,650	47,060	271,590	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,821,569	91,130	3,730,439	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	688,863	16,631	672,232	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,542,418	139,129	5,403,289	0	0
74.00	07400	RENAL DIALYSIS	151,199	3,703	147,496	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,836,168	316,870	3,519,298	0	0
91.00	09100	EMERGENCY	4,986,875	342,176	4,644,699	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,218,584	279,701	2,938,883	0	0
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	53,759,489	3,955,606	49,803,883	0	0
201.00		Less Observation Beds	3,218,584	279,701	2,938,883	0	0
202.00		Total (line 200 minus line 201)	50,540,905	3,675,905	46,865,000	0	0

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

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,316,269	34,438,722	0.212443	50.00
51.00	05100	RECOVERY ROOM	579,444	4,227,115	0.137078	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	717,338	3,820,895	0.187741	52.00
53.00	05300	ANESTHESIOLOGY	1,102,163	4,828,530	0.228261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,845,181	13,515,940	0.210506	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,222,141	6,300,895	0.193963	55.00
56.00	05600	RADIOISOTOPE	707,575	6,749,575	0.104833	56.00
57.00	05700	CT SCAN	1,683,116	35,548,316	0.047347	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	338,046	6,754,506	0.050047	58.00
59.00	05900	CARDIAC CATHETERIZATION	361,183	925,050	0.390447	59.00
60.00	06000	LABORATORY	5,866,657	49,943,804	0.117465	60.00
64.00	06400	INTRAVENOUS THERAPY	648,982	1,756,172	0.369544	64.00
65.00	06500	RESPIRATORY THERAPY	2,144,605	11,444,790	0.187387	65.00
66.00	06600	PHYSICAL THERAPY	2,631,183	6,928,668	0.379753	66.00
66.01	03340	CLINICAL NUTRITION	334,634	51,405	6.509756	66.01
67.00	06700	OCCUPATIONAL THERAPY	257,349	706,255	0.364385	67.00
68.00	06800	SPEECH PATHOLOGY	245,994	444,601	0.553292	68.00
69.00	06900	ELECTROCARDIOLOGY	2,008,572	15,736,645	0.127637	69.00
69.01	03140	CARDIAC REHABILITATION	184,731	552,535	0.334334	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	318,650	1,039,325	0.306593	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,821,569	3,620,061	1.055664	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	688,863	1,385,463	0.497208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,542,418	30,245,014	0.183251	73.00
74.00	07400	RENAL DIALYSIS	151,199	448,450	0.337159	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,836,168	5,263,003	0.728893	90.00
91.00	09100	EMERGENCY	4,986,875	27,491,832	0.181395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,218,584	2,592,466	1.241514	92.00
OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT	0	0	0.000000	99.30
200.00		Subtotal (sum of lines 50 thru 199)	53,759,489	276,760,033		200.00
201.00		Less Observation Beds	3,218,584	0		201.00
202.00		Total (line 200 minus line 201)	50,540,905	276,760,033		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 2:13 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	1,635,041	0	1,635,041	14,205	115.10	30.00
31.00	INTENSIVE CARE UNIT	219,744		219,744	1,304	168.52	31.00
40.00	SUBPROVIDER - IPF	342,963	0	342,963	5,250	65.33	40.00
43.00	NURSERY	108,822		108,822	484	224.84	43.00
200.00	Total (lines 30 through 199)	2,306,570		2,306,570	21,243		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	7,732	889,953				30.00
31.00	INTENSIVE CARE UNIT	838	141,220				31.00
40.00	SUBPROVIDER - IPF	1,528	99,824				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	10,098	1,130,997				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,028,196	34,438,722	0.029856	4,795,910	143,187	50.00
51.00	05100	RECOVERY ROOM	17,033	4,227,115	0.004029	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,423	3,820,895	0.035966	10,680	384	52.00
53.00	05300	ANESTHESIOLOGY	78,417	4,828,530	0.016240	623,480	10,125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	307,662	13,515,940	0.022763	1,598,985	36,398	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	47,301	6,300,895	0.007507	0	0	55.00
56.00	05600	RADIOISOTOPE	36,140	6,749,575	0.005354	234,540	1,256	56.00
57.00	05700	CT SCAN	98,049	35,548,316	0.002758	4,554,230	12,561	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,813	6,754,506	0.002785	412,195	1,148	58.00
59.00	05900	CARDIAC CATHETERIZATION	53,141	925,050	0.057447	7,540	433	59.00
60.00	06000	LABORATORY	311,698	49,943,804	0.006241	10,233,033	63,864	60.00
64.00	06400	INTRAVENOUS THERAPY	37,620	1,756,172	0.021422	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,688	11,444,790	0.008536	4,354,067	37,166	65.00
66.00	06600	PHYSICAL THERAPY	232,470	6,928,668	0.033552	946,172	31,746	66.00
66.01	03340	CLINICAL NUTRITION	9,000	51,405	0.175080	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,095	706,255	0.010046	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,270	444,601	0.043342	79,265	3,436	68.00
69.00	06900	ELECTROCARDIOLOGY	176,965	15,736,645	0.011245	3,570,915	40,155	69.00
69.01	03140	CARDIAC REHABILITATION	5,225	552,535	0.009456	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	47,060	1,039,325	0.045279	730	33	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,130	3,620,061	0.025174	1,922,154	48,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,631	1,385,463	0.012004	478,373	5,742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,129	30,245,014	0.004600	8,138,662	37,438	73.00
74.00	07400	RENAL DIALYSIS	3,703	448,450	0.008257	242,450	2,002	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	316,870	5,263,003	0.060207	320	19	90.00
91.00	09100	EMERGENCY	342,176	27,491,832	0.012446	3,391,255	42,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	279,701	2,592,466	0.107890	260,093	28,061	92.00
200.00		Total (lines 50 through 199)	3,955,606	276,760,033		45,855,049	545,750	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 2:13 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	14,205	0.00	7,732		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	1,304	0.00	838		31.00
40.00	04000	SUBPROVIDER - IPF		0	0	5,250	0.00	1,528		40.00
43.00	04300	NURSERY		0	0	484	0.00	0		43.00
200.00		Total (lines 30 through 199)		0	0	21,243		10,098		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
40.00	04000	SUBPROVIDER - IPF		0						40.00
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
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
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:13 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	34,438,722	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,227,115	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,820,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,828,530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,515,940	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,300,895	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,749,575	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,548,316	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,754,506	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	925,050	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,943,804	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,756,172	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,444,790	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,928,668	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	51,405	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	706,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,736,645	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	552,535	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,039,325	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,620,061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,385,463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,245,014	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	448,450	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,263,003	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,491,832	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,592,466	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	276,760,033		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,795,910	0	9,306,527	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	10,680	0	1,560	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	623,480	0	1,023,080	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,598,985	0	6,569,230	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	234,540	0	3,376,370	0	56.00
57.00	05700	CT SCAN	0.000000	4,554,230	0	10,316,740	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	412,195	0	2,266,785	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	7,540	0	253,605	0	59.00
60.00	06000	LABORATORY	0.000000	10,233,033	0	6,414,879	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	168,910	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,354,067	0	2,117,040	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	946,172	0	47,295	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	79,265	0	81,760	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,570,915	0	4,966,860	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	282,610	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	730	0	49,565	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,922,154	0	267,542	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	478,373	0	261,042	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,138,662	0	11,600,416	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	242,450	0	32,250	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	320	0	30,480	0	90.00
91.00	09100	EMERGENCY	0.000000	3,391,255	0	7,205,968	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	260,093	0	1,151,934	0	92.00
200.00		Total (lines 50 through 199)		45,855,049	0	67,792,448	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 2:13 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	0.212443	9,306,527	0	0	1,977,107	50.00
51.00	05100	RECOVERY ROOM	0.137078	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.187741	1,560	0	0	293	52.00
53.00	05300	ANESTHESIOLOGY	0.228261	1,023,080	0	0	233,529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210506	6,569,230	0	0	1,382,862	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193963	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.104833	3,376,370	0	0	353,955	56.00
57.00	05700	CT SCAN	0.047347	10,316,740	0	0	488,467	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050047	2,266,785	0	0	113,446	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.390447	253,605	0	0	99,019	59.00
60.00	06000	LABORATORY	0.117465	6,414,879	0	0	753,524	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369544	168,910	0	0	62,420	64.00
65.00	06500	RESPIRATORY THERAPY	0.187387	2,117,040	0	0	396,706	65.00
66.00	06600	PHYSICAL THERAPY	0.379753	47,295	0	0	17,960	66.00
66.01	03340	CLINICAL NUTRITION	6.509756	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.364385	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553292	81,760	0	0	45,237	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127637	4,966,860	0	0	633,955	69.00
69.01	03140	CARDIAC REHABILITATION	0.334334	282,610	0	0	94,486	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.306593	49,565	0	0	15,196	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664	267,542	0	0	282,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497208	261,042	0	0	129,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183251	11,600,416	0	162,483	2,125,788	73.00
74.00	07400	RENAL DIALYSIS	0.337159	32,250	0	0	10,873	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.728893	30,480	0	0	22,217	90.00
91.00	09100	EMERGENCY	0.181395	7,205,968	0	0	1,307,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.241514	1,151,934	0	0	1,430,142	92.00
200.00		Subtotal (see instructions)		67,792,448	0	162,483	11,976,535	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		67,792,448	0	162,483	11,976,535	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 2:13 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
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
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
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	29,775		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	29,775		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	29,775		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 8/27/2020 2:13 pm		
					Title XVIII		Subprovider - IPF		PPS		
	Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)			
				1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM		1,028,196	34,438,722	0.029856	0	0	50.00		
51.00	05100	RECOVERY ROOM		17,033	4,227,115	0.004029	0	0	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM		137,423	3,820,895	0.035966	0	0	52.00		
53.00	05300	ANESTHESIOLOGY		78,417	4,828,530	0.016240	0	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC		307,662	13,515,940	0.022763	14,975	341	54.00		
55.00	05500	RADIOLOGY-THERAPEUTIC		47,301	6,300,895	0.007507	0	0	55.00		
56.00	05600	RADIOISOTOPE		36,140	6,749,575	0.005354	0	0	56.00		
57.00	05700	CT SCAN		98,049	35,548,316	0.002758	47,625	131	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		18,813	6,754,506	0.002785	31,945	89	58.00		
59.00	05900	CARDIAC CATHETERIZATION		53,141	925,050	0.057447	0	0	59.00		
60.00	06000	LABORATORY		311,698	49,943,804	0.006241	401,140	2,504	60.00		
64.00	06400	INTRAVENOUS THERAPY		37,620	1,756,172	0.021422	0	0	64.00		
65.00	06500	RESPIRATORY THERAPY		97,688	11,444,790	0.008536	100,930	862	65.00		
66.00	06600	PHYSICAL THERAPY		232,470	6,928,668	0.033552	13,975	469	66.00		
66.01	03340	CLINICAL NUTRITION		9,000	51,405	0.175080	0	0	66.01		
67.00	06700	OCCUPATIONAL THERAPY		7,095	706,255	0.010046	0	0	67.00		
68.00	06800	SPEECH PATHOLOGY		19,270	444,601	0.043342	1,455	63	68.00		
69.00	06900	ELECTROCARDIOLOGY		176,965	15,736,645	0.011245	28,940	325	69.00		
69.01	03140	CARDIAC REHABILITATION		5,225	552,535	0.009456	0	0	69.01		
70.00	07000	ELECTROENCEPHALOGRAPHY		47,060	1,039,325	0.045279	0	0	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		91,130	3,620,061	0.025174	14,350	361	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		16,631	1,385,463	0.012004	0	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS		139,129	30,245,014	0.004600	141,625	651	73.00		
74.00	07400	RENAL DIALYSIS		3,703	448,450	0.008257	2,660	22	74.00		
	OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC		316,870	5,263,003	0.060207	450	27	90.00		
91.00	09100	EMERGENCY		342,176	27,491,832	0.012446	136,915	1,704	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	2,592,466	0.000000	0	0	92.00		
200.00		Total (lines 50 through 199)		3,675,905	276,760,033		936,985	7,549	200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:13 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
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
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
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	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:13 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) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	34,438,722	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	4,227,115	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	3,820,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,828,530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	13,515,940	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	6,300,895	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,749,575	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	35,548,316	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	6,754,506	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	925,050	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	49,943,804	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,756,172	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	11,444,790	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,928,668	0.000000	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	51,405	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	706,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	444,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	15,736,645	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	552,535	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,039,325	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	3,620,061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,385,463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	30,245,014	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	448,450	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,263,003	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	27,491,832	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	2,592,466	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	276,760,033		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:

Worksheet D

Component CCN: 14-S034

From 01/01/2019
To 12/31/2019

Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	14,975	0	785	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN		0.000000	47,625	0	4,300	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	31,945	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY		0.000000	401,140	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	100,930	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY		0.000000	13,975	0	0	0 66.00
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	1,455	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	28,940	0	425	0 69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	14,350	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	141,625	0	70	0 73.00
74.00	07400	RENAL DIALYSIS		0.000000	2,660	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0.000000	450	0	448,115	0 90.00
91.00	09100	EMERGENCY		0.000000	136,915	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)			936,985	0	453,695	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/27/2020 2:13 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.212443	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.137078	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.187741	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.228261	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210506	785	0	0	165	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.193963	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.104833	0	0	0	0	56.00
57.00	05700	CT SCAN	0.047347	4,300	0	0	204	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050047	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.390447	0	0	0	0	59.00
60.00	06000	LABORATORY	0.117465	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369544	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.187387	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379753	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	6.509756	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.364385	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553292	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127637	425	0	0	54	69.00
69.01	03140	CARDIAC REHABILITATION	0.334334	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.306593	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497208	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183251	70	0	0	13	73.00
74.00	07400	RENAL DIALYSIS	0.337159	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.728893	448,115	0	0	326,628	90.00
91.00	09100	EMERGENCY	0.181395	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.241514	0	0	0	0	92.00
200.00		Subtotal (see instructions)		453,695	0	0	327,064	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		453,695	0	0	327,064	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/27/2020 2:13 pm		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
66.01	03340	CLINICAL NUTRITION	0	0					66.01
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
69.01	03140	CARDIAC REHABILITATION	0	0					69.01
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									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,635,041	0	1,635,041	14,205	115.10	30.00
31.00	INTENSIVE CARE UNIT		219,744		219,744	1,304	168.52	31.00
40.00	SUBPROVIDER - IPF		342,963	0	342,963	5,250	65.33	40.00
43.00	NURSERY		108,822		108,822	484	224.84	43.00
200.00	Total (lines 30 through 199)		2,306,570		2,306,570	21,243		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		233	26,818				
31.00	INTENSIVE CARE UNIT		45	7,583				
40.00	SUBPROVIDER - IPF		632	41,289				
43.00	NURSERY		183	41,146				
200.00	Total (lines 30 through 199)		1,093	116,836				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,028,196	34,438,722	0.029856	0	0	50.00
51.00	05100 RECOVERY ROOM	17,033	4,227,115	0.004029	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	137,423	3,820,895	0.035966	0	0	52.00
53.00	05300 ANESTHESIOLOGY	78,417	4,828,530	0.016240	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	307,662	13,515,940	0.022763	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	47,301	6,300,895	0.007507	0	0	55.00
56.00	05600 RADIOISOTOPE	36,140	6,749,575	0.005354	0	0	56.00
57.00	05700 CT SCAN	98,049	35,548,316	0.002758	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	18,813	6,754,506	0.002785	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	53,141	925,050	0.057447	0	0	59.00
60.00	06000 LABORATORY	311,698	49,943,804	0.006241	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	37,620	1,756,172	0.021422	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	97,688	11,444,790	0.008536	0	0	65.00
66.00	06600 PHYSICAL THERAPY	232,470	6,928,668	0.033552	0	0	66.00
66.01	03340 CLINICAL NUTRITION	9,000	51,405	0.175080	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	7,095	706,255	0.010046	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	19,270	444,601	0.043342	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	176,965	15,736,645	0.011245	0	0	69.00
69.01	03140 CARDIAC REHABILITATION	5,225	552,535	0.009456	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	47,060	1,039,325	0.045279	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91,130	3,620,061	0.025174	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,631	1,385,463	0.012004	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	139,129	30,245,014	0.004600	0	0	73.00
74.00	07400 RENAL DIALYSIS	3,703	448,450	0.008257	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	316,870	5,263,003	0.060207	0	0	90.00
91.00	09100 EMERGENCY	342,176	27,491,832	0.012446	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	279,701	2,592,466	0.107890	0	0	92.00
200.00	Total (lines 50 through 199)	3,955,606	276,760,033		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 2:13 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	14,205	0.00	233		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	1,304	0.00	45		31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	5,250	0.00	632		40.00	
43.00	04300	NURSERY		0	0	484	0.00	183		43.00	
200.00		Total (lines 30 through 199)		0	0	21,243		1,093		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician	Nursing School	Nursing School	Allied Health	Allied Health		
		Anesthetist Cost	Post-Stepdown Adjustments	Post-Stepdown Adjustments	Post-Stepdown Adjustments	Post-Stepdown Adjustments		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
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
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	34,438,722	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,227,115	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,820,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,828,530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,515,940	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,300,895	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,749,575	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,548,316	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,754,506	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	925,050	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,943,804	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,756,172	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,444,790	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,928,668	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	51,405	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	706,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,736,645	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	552,535	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,039,325	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,620,061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,385,463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,245,014	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	448,450	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,263,003	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,491,832	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,592,466	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	276,760,033		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

				Title XIX		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	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:

Worksheet D

Component CCN: 14-S034

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/27/2020 2:13 pm

Title XIX

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,028,196	34,438,722	0.029856	0	50.00
51.00	05100	RECOVERY ROOM	17,033	4,227,115	0.004029	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,423	3,820,895	0.035966	0	52.00
53.00	05300	ANESTHESIOLOGY	78,417	4,828,530	0.016240	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	307,662	13,515,940	0.022763	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	47,301	6,300,895	0.007507	0	55.00
56.00	05600	RADIOISOTOPE	36,140	6,749,575	0.005354	0	56.00
57.00	05700	CT SCAN	98,049	35,548,316	0.002758	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,813	6,754,506	0.002785	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	53,141	925,050	0.057447	0	59.00
60.00	06000	LABORATORY	311,698	49,943,804	0.006241	0	60.00
64.00	06400	INTRAVENOUS THERAPY	37,620	1,756,172	0.021422	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,688	11,444,790	0.008536	0	65.00
66.00	06600	PHYSICAL THERAPY	232,470	6,928,668	0.033552	0	66.00
66.01	03340	CLINICAL NUTRITION	9,000	51,405	0.175080	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,095	706,255	0.010046	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,270	444,601	0.043342	0	68.00
69.00	06900	ELECTROCARDIOLOGY	176,965	15,736,645	0.011245	0	69.00
69.01	03140	CARDIAC REHABILITATION	5,225	552,535	0.009456	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	47,060	1,039,325	0.045279	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,130	3,620,061	0.025174	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,631	1,385,463	0.012004	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,129	30,245,014	0.004600	0	73.00
74.00	07400	RENAL DIALYSIS	3,703	448,450	0.008257	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	316,870	5,263,003	0.060207	0	90.00
91.00	09100	EMERGENCY	342,176	27,491,832	0.012446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,592,466	0.000000	0	92.00
200.00		Total (lines 50 through 199)	3,675,905	276,760,033		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:13 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
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
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
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	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034
Component CCN: 14-S034

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

Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:13 pm

			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	34,438,722	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,227,115	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,820,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,828,530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,515,940	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,300,895	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,749,575	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,548,316	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,754,506	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	925,050	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,943,804	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,756,172	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,444,790	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,928,668	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	51,405	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	706,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,736,645	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	552,535	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,039,325	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,620,061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,385,463	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,245,014	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	448,450	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,263,003	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,491,832	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,592,466	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	276,760,033		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:13 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,205	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,205	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)			11,775	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			7,732	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			18,814,765	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			18,814,765	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			18,814,765	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)			1,324.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			10,241,189	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)			10,241,189	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:13 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	3,587,346	1,304	2,751.03	838	2,305,363
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)					9,422,981
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,969,533
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,031,173
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					545,750
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,576,923
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,392,610
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,430
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,324.52
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,218,584

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,635,041	18,814,765	0.086902	3,218,584	279,701 90.00
91.00	Nursing School cost	0	18,814,765	0.000000	3,218,584	0 91.00
92.00	Allied health cost	0	18,814,765	0.000000	3,218,584	0 92.00
93.00	All other Medical Education	0	18,814,765	0.000000	3,218,584	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 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)		5,250	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,250	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)		5,250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,528	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,580,576	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,580,576	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,580,576	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)		1,062.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,624,218	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)		1,624,218	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					150,163
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,774,381
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					99,824
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,549
52.00 Total Program excludable cost (sum of lines 50 and 51)					107,373
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,667,008
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 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	342,963	5,580,576	0.061457	0	0 90.00
91.00	Nursing School cost	0	5,580,576	0.000000	0	0 91.00
92.00	Allied health cost	0	5,580,576	0.000000	0	0 92.00
93.00	All other Medical Education	0	5,580,576	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm	
Cost Center Description		Title XIX	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,205	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,205	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)			11,775	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			233	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)			484	15.00
16.00	Nursery days (title V or XIX only)			183	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			18,814,765	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			18,814,765	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			18,814,765	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)			1,324.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			308,613	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)			308,613	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:13 pm

			Title XIX		Hospital	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)	1,318,654	484	2,724.49	183	498,582	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,587,346	1,304	2,751.03	45	123,796	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						930,991	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)						75,547	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						75,547	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						855,444	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						2,430	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,324.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						3,218,584	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,635,041	18,814,765	0.086902	3,218,584	279,701 90.00
91.00	Nursing School cost	0	18,814,765	0.000000	3,218,584	0 91.00
92.00	Allied health cost	0	18,814,765	0.000000	3,218,584	0 92.00
93.00	All other Medical Education	0	18,814,765	0.000000	3,218,584	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,250	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,250	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)		5,250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		632	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)		484	15.00
16.00	Nursery days (title V or XIX only)		183	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,580,576	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,580,576	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,580,576	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)		1,062.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		671,797	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)		671,797	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm
			Title XIX	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					671,797
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					41,289
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					41,289
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					630,508
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 2:13 pm	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	342,963	5,580,576	0.061457	0	0	90.00
91.00	Nursing School cost	0	5,580,576	0.000000	0	0	91.00
92.00	Allied health cost	0	5,580,576	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,580,576	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 2:13 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		10,651,960		30.00
31.00	03100	INTENSIVE CARE UNIT		1,904,605		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212443	4,795,910	1,018,858	50.00
51.00	05100	RECOVERY ROOM	0.137078	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.187741	10,680	2,005	52.00
53.00	05300	ANESTHESIOLOGY	0.228261	623,480	142,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210506	1,598,985	336,596	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.199606	0	0	55.00
56.00	05600	RADIOISOTOPE	0.104833	234,540	24,588	56.00
57.00	05700	CT SCAN	0.047347	4,554,230	215,629	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050047	412,195	20,629	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.390447	7,540	2,944	59.00
60.00	06000	LABORATORY	0.117465	10,233,033	1,202,023	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369544	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.187432	4,354,067	816,091	65.00
66.00	06600	PHYSICAL THERAPY	0.379753	946,172	359,312	66.00
66.01	03340	CLINICAL NUTRITION	6.509756	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.364385	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553292	79,265	43,857	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127637	3,570,915	455,781	69.00
69.01	03140	CARDIAC REHABILITATION	0.334334	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.307089	730	224	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664	1,922,154	2,029,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.497208	478,373	237,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183251	8,138,662	1,491,418	73.00
74.00	07400	RENAL DIALYSIS	0.337159	242,450	81,744	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.732730	320	234	90.00
91.00	09100	EMERGENCY	0.182476	3,391,255	618,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.241514	260,093	322,909	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		45,855,049	9,422,981	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)		45,855,049		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 2:13 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		1,647,745		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.212443	0	0	50.00
51.00	05100 RECOVERY ROOM	0.137078	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.187741	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.228261	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.210506	14,975	3,152	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.199606	0	0	55.00
56.00	05600 RADIOISOTOPE	0.104833	0	0	56.00
57.00	05700 CT SCAN	0.047347	47,625	2,255	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050047	31,945	1,599	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.390447	0	0	59.00
60.00	06000 LABORATORY	0.117465	401,140	47,120	60.00
64.00	06400 INTRAVENOUS THERAPY	0.369544	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.187432	100,930	18,918	65.00
66.00	06600 PHYSICAL THERAPY	0.379753	13,975	5,307	66.00
66.01	03340 CLINICAL NUTRITION	6.509756	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.364385	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.553292	1,455	805	68.00
69.00	06900 ELECTROCARDIOLOGY	0.127637	28,940	3,694	69.00
69.01	03140 CARDIAC REHABILITATION	0.334334	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.307089	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.055664	14,350	15,149	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.497208	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.183251	141,625	25,953	73.00
74.00	07400 RENAL DIALYSIS	0.337159	2,660	897	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.732730	450	330	90.00
91.00	09100 EMERGENCY	0.182476	136,915	24,984	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.241514	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		936,985	150,163	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		936,985		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 2:13 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,877,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,049,279	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)		131,986	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		31,249	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		85.34	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.85	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.78	31.00
32.00	Sum of lines 30 and 31		22.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.88	33.00
34.00	Disproportionate share adjustment (see instructions)		274,349	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 2:13 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000097481	0.000074348
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		806,445	620,854
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		603,177	156,062
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		759,239	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		15,123,137	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		16,799,427	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		16,380,355	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,138,440	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,518,795	59.00
60.00	Primary payer payments		6,053	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,512,742	61.00
62.00	Deductibles billed to program beneficiaries		1,891,508	62.00
63.00	Coinurance billed to program beneficiaries		19,096	63.00
64.00	Allowable bad debts (see instructions)		563,760	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		366,444	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		471,787	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,968,582	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		14,417	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-9,781	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		161,793	70.93
70.94	HRR adjustment amount (see instructions)		-112,775	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 2:13 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)		16,022,236	71.00
71.01	Sequestration adjustment (see instructions)		320,445	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		15,687,985	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		13,806	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		384,601	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)		940,330	316,888
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		1.0126144634	1.0080619968
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		11,862	2,555
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9898	0.9994
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-9,591	-190
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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 2:13 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,877,035	0	10,877,035		10,877,035
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,049,279	0		3,049,279	3,049,279
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	131,986	0	131,986		131,986
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,249	0		31,249	31,249
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0788	0.0788	0.0788	0.0788	
11.00	Disproportionate share adjustment (see instructions)	34.00	274,349	0	214,278	60,071	274,349
11.01	Uncompensated care payments	36.00	759,239	0	603,177	202,713	805,890
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	15,123,137	0	11,779,825	3,343,312	15,123,137
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	16,799,427	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,380,355	0	13,037,043	3,343,312	16,380,355
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,138,440	0	896,617	241,823	1,138,440

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 2:13 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	13,933,660	3,585,135	17,518,795
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,120,657	0	878,834	241,823	1,120,657
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	17,783	0	17,783	0	17,783
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	1,138,440	0	896,617	241,823	1,138,440
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 2:13 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,877,035	10,877,035		10,877,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,049,279		3,049,279	3,049,279	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	131,986	131,986		131,986	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,249		31,249	31,249	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0788	0.0788	0.0788		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	274,349	214,278	60,071	274,349	11.00
11.01	Uncompensated care payments	36.00	759,239	603,177	202,713	805,890	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,123,137	11,779,825	3,343,312	15,123,137	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	16,799,427	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,380,355	13,037,043	3,343,312	16,380,355	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,138,440	896,617	241,823	1,138,440	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			13,933,660	3,585,135	17,518,795	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 2:13 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,120,657	878,834	241,823	1,120,657	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	17,783	17,783	0	17,783	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,138,440	896,617	241,823	1,138,440	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	161,793	137,209	24,584	161,793	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	14,417	11,862	2,555	14,417	30.01
31.00	HRR adjustment (see instructions)	70.94	-112,775	-110,945	-1,830	-112,775	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-9,781	-9,591	-190	-9,781	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 2:13 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		29,775	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,976,535	2.00
3.00	OPPS payments		10,408,365	3.00
4.00	Outlier payment (see instructions)		29,955	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)		29,775	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		162,483	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)		162,483	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)		162,483	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		132,708	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		29,775	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		10,438,320	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,058,569	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,409,526	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,409,526	30.00
31.00	Primary payer payments		128	31.00
32.00	Subtotal (line 30 minus line 31)		8,409,398	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)		268,274	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		174,378	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		179,725	36.00
37.00	Subtotal (see instructions)		8,583,776	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,583,776	40.00
40.01	Sequestration adjustment (see instructions)		171,676	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		8,404,244	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		7,856	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 2:13 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		327,064	2.00
3.00	OPPS payments		115,891	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		115,891	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)		25,838	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)		90,053	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)		90,053	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		90,053	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)		90,053	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)		90,053	40.00
40.01	Sequestration adjustment (see instructions)		1,801	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		88,251	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		1	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 2:13 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		15,394,349		8,244,128	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		411,319		205,578	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	08/12/2019	117,683	08/12/2019	45,462	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)		-117,683		-45,462	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)		15,687,985		8,404,244	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		13,806		7,856	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,701,791		8,412,100	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: 14-0034

Period:

Worksheet E-1

Component CCN: 14-S034

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/27/2020 2:13 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		1,252,437		88,251	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)		1,252,437		88,251	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		57,384		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,309,821		88,252	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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/27/2020 2:13 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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/27/2020 2:13 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)			1,470,335 1.00
2.00	Net IPF PPS Outlier Payments			0 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)			14.383562 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)			1,470,335 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)			1,470,335 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,470,335 18.00
19.00	Deductibles			192,324 19.00
20.00	Subtotal (line 18 minus line 19)			1,278,011 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			1,278,011 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			90,063 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			58,541 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			76,823 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,336,552 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,336,552 31.00
31.01	Sequestration adjustment (see instructions)			26,731 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,252,437 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)			57,384 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			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0034

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

Worksheet G

Date/Time Prepared:
8/27/2020 2:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,953,241	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,451,006	0	0	0	4.00
5.00	Other receivable	653,161	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,296,356	0	0	0	7.00
8.00	Prepaid expenses	533,075	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,886,839	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,259,000	0	0	0	12.00
13.00	Land improvements	667,527	0	0	0	13.00
14.00	Accumulated depreciation	-667,527	0	0	0	14.00
15.00	Buildings	42,761,723	0	0	0	15.00
16.00	Accumulated depreciation	-16,767,420	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	5,692,302	0	0	0	19.00
20.00	Accumulated depreciation	-2,476,795	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,180,192	0	0	0	23.00
24.00	Accumulated depreciation	-20,566,905	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)	41,082,097	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,042,639	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	-4,810	1,138,379	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,037,829	1,138,379	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,006,765	1,138,379	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,424,107	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,265,940	0	0	0	38.00
39.00	Payroll taxes payable	64,081	0	0	0	39.00
40.00	Notes and loans payable (short term)	612,863	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-317,932	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,049,059	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	45,818,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,730,263	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	54,548,263	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	63,597,322	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,409,443				52.00
53.00	Specific purpose fund		1,138,379			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,409,443	1,138,379	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,006,765	1,138,379	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0034

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

Worksheet G-1

Date/Time Prepared:
8/27/2020 2:13 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		-7,205,755		680,357		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,558,486				2.00
3.00	Total (sum of line 1 and line 2)		7,352,731		680,357		3.00
4.00	Additions	4,233		464,607		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		4,233		464,607		10.00
11.00	Subtotal (line 3 plus line 10)		7,356,964		1,144,964		11.00
12.00	Deductions	3,941,656		4,233		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZ	5,865		0		0	15.00
16.00	TRANSFER TO OTHER FUNDS	0		2,352		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,947,521		6,585		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,409,443		1,138,379		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZ		0				15.00
16.00	TRANSFER TO OTHER FUNDS		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: 14-0034

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 2:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	21,183,542		21,183,542	1.00
2.00	SUBPROVIDER - IPF	5,699,538		5,699,538	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	26,883,080		26,883,080	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,328,558		3,328,558	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)	3,328,558		3,328,558	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,211,638		30,211,638	17.00
18.00	Ancillary services	77,240,387	164,172,450	241,412,837	18.00
19.00	Outpatient services	7,039,427	28,307,874	35,347,301	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.30	OOT	0	0	0	24.30
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PROFESSIONAL FEES	5,560,315	7,408,060	12,968,375	27.00
27.01	EMPLOYEE HEALTH INSURANCE	1,241,326	4,304,610	5,545,936	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	121,293,093	204,192,994	325,486,087	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		96,375,967		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)		96,375,967		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0034

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

Worksheet G-3

Date/Time Prepared:
8/27/2020 2:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	325,486,087	1.00
2.00	Less contractual allowances and discounts on patients' accounts	217,211,219	2.00
3.00	Net patient revenues (line 1 minus line 2)	108,274,868	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	96,375,967	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,898,901	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	134,175	6.00
7.00	Income from investments	4,279	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	269,481	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,267	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	228,548	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,021,835	24.00
25.00	Total other income (sum of lines 6-24)	2,659,585	25.00
26.00	Total (line 5 plus line 25)	14,558,486	26.00
27.00	OTHER EXPENSES	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)	14,558,486	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0034	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/27/2020 2:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,120,657	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,783	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		36.16	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,138,440	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