

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: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 2:16 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.		Date: 8/27/2020 Time: 2:16 pm
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 GOOD SAMARITAN HOSPITAL (14-0046) 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	66,069	29,897	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-6,064	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	60,005	29,897	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: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 2:16 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 GOOD SAMARITAN WAY			PO Box:				1.00			
2.00	City: MT. VERNON			State: IL		Zip Code: 62864		County: JEFFERSON			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SSM HEALTH GOOD SAMARITAN HOSPITAL		140046	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF										
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT		14T046	99914	5	01/01/1990	N	P	P
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2019		12/31/2019	20.00
21.00	Type of Control (see instructions)							1			21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,232	573	0	6	4,152	273		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 2:16 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	42	21	0	0	64			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

Worksheet S-2
Part I
Date/Time Prepared:
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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.				N				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0		71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0		76.00

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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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 2:16 pm
		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:	4,044,920	198	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 2:16 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: BRIAN SCHMEIDLER		Contractor's Name: A		Contractor's Number: 05301				141.00	
142.00	Street: 1195 CORPORATE LAKE DRIVE		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				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.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 2:16 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.	Y		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	03/28/2018	Y 03/28/2018
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: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 2:16 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.	BRIAN	SCHMEIDLER	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.	314-989-3524	BRIAN.SCHMEIDLER@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 2:16 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.	REGIONAL DIRECTOR GOVERNMENT REIMBUR	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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:16 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	99	36,135	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)		99	36,135	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		115	41,975	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:16 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)	13,313	633	23,711			1.00
2.00	HMO and other (see instructions)	1,730	4,731				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	50				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	13,313	633	23,711			7.00
8.00	INTENSIVE CARE UNIT	1,220	169	2,076			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		430	1,951			13.00
14.00	Total (see instructions)	14,533	1,232	27,738	0.00	804.61	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,613	74	2,150	0.00	12.59	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	817.20	27.00
28.00	Observation Bed Days		116	2,023			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			371			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	273	454			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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 2:16 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	3,131	616	8,163	1.00
2.00 HMO and other (see instructions)			377	1,569		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				5		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	3,131	616	8,163	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	129	6	178	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 2:16 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	53,833,578	0	53,833,578	1,699,767.00	31.67
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		230,164	0	230,164	1,458.85	157.77
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)		2,009,201	0	2,009,201	21,619.18	92.94
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,151,490	0	2,151,490	26,822.41	80.21
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		6,996,533	0	6,996,533	194,024.63	36.06
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)		23,978,545	0	23,978,545		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		260,171	0	260,171		
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)		2,501,321	0	2,501,321		
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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/27/2020 2:16 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	265,472	0	265,472	1,887.01	140.68	26.00
27.00	Administrative & General	5.00	3,913,480	0	3,913,480	104,642.64	37.40	27.00
28.00	Administrative & General under contract (see inst.)		653,516	0	653,516	5,058.56	129.19	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	875,042	0	875,042	37,656.01	23.24	30.00
31.00	Laundry & Linen Service	8.00	114,500	0	114,500	7,656.85	14.95	31.00
32.00	Housekeeping	9.00	1,422,595	0	1,422,595	98,423.16	14.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,175,655	-253,967	921,688	16,636.77	55.40	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	253,967	253,967	60,378.56	4.21	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	874,879	0	874,879	19,646.76	44.53	38.00
39.00	Central Services and Supply	14.00	355,624	0	355,624	19,755.02	18.00	39.00
40.00	Pharmacy	15.00	2,045,078	0	2,045,078	49,710.28	41.14	40.00
41.00	Medical Records & Medical Records Library	16.00	239,786	0	239,786	13,937.80	17.20	41.00
42.00	Social Service	17.00	1,075,693	0	1,075,693	33,648.99	31.97	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/27/2020 2:16 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)	54,487,094	0	54,487,094	1,704,825.56	31.96	1.00
2.00	Excluded area salaries (see instructions)	2,009,201	0	2,009,201	21,619.18	92.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,477,893	0	52,477,893	1,683,206.38	31.18	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,148,023	0	9,148,023	220,847.04	41.42	4.00
5.00	Subtotal wage-related costs (see inst.)	26,479,866	0	26,479,866	0.00	50.46	5.00
6.00	Total (sum of lines 3 thru 5)	88,105,782	0	88,105,782	1,904,053.42	46.27	6.00
7.00	Total overhead cost (see instructions)	13,011,320	0	13,011,320	469,038.41	27.74	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/27/2020 2:16 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,876,764	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		4,523,000	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)		11,612,189	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		649,805	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		237,234	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)		301,368	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		486,997	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		3,783,242	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		215,572	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		502,410	22.00
23.00	Tuition Reimbursement		50,135	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		24,238,716	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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,165,823	24,238,716	1.00
2.00	Hospital	2,151,490	23,978,545	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	14,333	4,415	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	255,756	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/27/2020 2:16 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)		0.261293		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,547,245		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		1,553,692		5.00
6.00	Medicaid charges		108,958,868		6.00
7.00	Medicaid cost (line 1 times line 6)		28,470,189		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)		18,369,252		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)		18,369,252		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)	6,786,003	3,216,316	10,002,319	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,773,135	3,216,316	4,989,451	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,773,135	3,216,316	4,989,451	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,453,222		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		799,616		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,230,177		27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,223,045		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,534,013		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,523,464		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		24,892,716		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,148,702	14,148,702	1,222,246	15,370,948	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,593,533	5,593,533	0	5,593,533	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	265,472	23,001,138	23,266,610	0	23,266,610	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,913,480	29,151,889	33,065,369	595,982	33,661,351	5.00
7.00	00700	OPERATION OF PLANT	875,042	4,776,702	5,651,744	252,140	5,903,884	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,500	497,534	612,034	0	612,034	8.00
9.00	00900	HOUSEKEEPING	1,422,595	589,994	2,012,589	-250,022	1,762,567	9.00
10.00	01000	DIETARY	1,175,655	903,963	2,079,618	-442,025	1,637,593	10.00
11.00	01100	CAFETERIA	0	0	0	442,025	442,025	11.00
13.00	01300	NURSING ADMINISTRATION	874,879	171,669	1,046,548	0	1,046,548	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	355,624	322,426	678,050	-29,477	648,573	14.00
15.00	01500	PHARMACY	2,045,078	12,103,805	14,148,883	-11,572,269	2,576,614	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	239,786	151,082	390,868	0	390,868	16.00
17.00	01700	SOCIAL SERVICE	1,075,693	354,635	1,430,328	0	1,430,328	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,917,240	2,484,084	16,401,324	-16,755	16,384,569	30.00
31.00	03100	INTENSIVE CARE UNIT	1,871,150	897,055	2,768,205	-786,471	1,981,734	31.00
41.00	04100	SUBPROVIDER - IRF	913,535	72,109	985,644	-9,703	975,941	41.00
43.00	04300	NURSERY	0	0	0	566,392	566,392	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,422,789	7,717,839	10,140,628	-5,830,600	4,310,028	50.00
51.00	05100	RECOVERY ROOM	382,628	42,943	425,571	-36,596	388,975	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,940,228	762,523	3,702,751	-1,434,228	2,268,523	52.00
53.00	05300	ANESTHESIOLOGY	65,299	5,692,529	5,757,828	-226,660	5,531,168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,506,941	275,218	1,782,159	-136,526	1,645,633	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,155,465	324,229	1,479,694	-142,413	1,337,281	55.00
56.00	05600	RADIOISOTOPE	211,604	292,868	504,472	-11,952	492,520	56.00
57.00	05700	CT SCAN	486,691	117,116	603,807	-60,257	543,550	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,372	130,340	341,712	-25,481	316,231	58.00
59.00	05900	CARDIAC CATHETERIZATION	925,697	3,096,556	4,022,253	-2,947,083	1,075,170	59.00
60.00	06000	LABORATORY	2,201,239	3,017,412	5,218,651	-125,175	5,093,476	60.00
64.00	06400	INTRAVENOUS THERAPY	363,992	44,793	408,785	-43,156	365,629	64.00
65.00	06500	RESPIRATORY THERAPY	1,302,742	444,313	1,747,055	-298,698	1,448,357	65.00
66.00	06600	PHYSICAL THERAPY	1,107,831	18,879	1,126,710	-8,637	1,118,073	66.00
66.01	03951	CLINICAL NUTRITION	222,454	380	222,834	0	222,834	66.01
67.00	06700	OCCUPATIONAL THERAPY	467,077	7,854	474,931	-4,431	470,500	67.00
68.00	06800	SPEECH PATHOLOGY	267,420	5,612	273,032	-3,420	269,612	68.00
69.00	06900	ELECTROCARDIOLOGY	788,725	864,100	1,652,825	-23,192	1,629,633	69.00
69.01	06901	CARDIAC REHABILITATION	196,036	20,283	216,319	-1,337	214,982	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	41,169	15,186	56,355	0	56,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,090,980	8,090,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,321,365	4,321,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,858	149,666	1,389,524	11,481,100	12,870,624	73.00
74.00	07400	RENAL DIALYSIS	38,000	538,166	576,166	-9,658	566,508	74.00
76.00	03950	ENDOSCOPY	106,440	142,351	248,791	-121,612	127,179	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,237,409	2,010,320	4,247,729	-156,272	4,091,457	90.00
91.00	09100	EMERGENCY	2,789,077	1,854,306	4,643,383	-398,798	4,244,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,737,912	122,806,102	175,544,014	1,819,326	177,363,340	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66,726	5,487	72,213	0	72,213	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	682,126	0	682,126	0	682,126	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	346,814	2,455,151	2,801,965	-1,819,326	982,639	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	817,296	817,296	0	817,296	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	53,833,578	126,084,036	179,917,614	0	179,917,614	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A

Date/Time Prepared:
8/27/2020 2:16 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	-1,480,487	13,890,461	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,169,416	1,424,117	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,362,532	25,629,142	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,488,382	26,172,969	5.00
7.00	00700	OPERATION OF PLANT	-614,122	5,289,762	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	612,034	8.00
9.00	00900	HOUSEKEEPING	-2,296	1,760,271	9.00
10.00	01000	DIETARY	0	1,637,593	10.00
11.00	01100	CAFETERIA	-706,503	-264,478	11.00
13.00	01300	NURSING ADMINISTRATION	-18,342	1,028,206	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	648,573	14.00
15.00	01500	PHARMACY	-77,367	2,499,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,579	382,289	16.00
17.00	01700	SOCIAL SERVICE	-34,148	1,396,180	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,908,078	10,476,491	30.00
31.00	03100	INTENSIVE CARE UNIT	-19,880	1,961,854	31.00
41.00	04100	SUBPROVIDER - IRF	-46,352	929,589	41.00
43.00	04300	NURSERY	0	566,392	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-631,042	3,678,986	50.00
51.00	05100	RECOVERY ROOM	0	388,975	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-300	2,268,223	52.00
53.00	05300	ANESTHESIOLOGY	-5,268,205	262,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,688	1,643,945	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-560,530	776,751	55.00
56.00	05600	RADIOISOTOPE	0	492,520	56.00
57.00	05700	CT SCAN	-2,615	540,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-5,898	310,333	58.00
59.00	05900	CARDIAC CATHETERIZATION	-369	1,074,801	59.00
60.00	06000	LABORATORY	-225,966	4,867,510	60.00
64.00	06400	INTRAVENOUS THERAPY	-1,500	364,129	64.00
65.00	06500	RESPIRATORY THERAPY	-36,611	1,411,746	65.00
66.00	06600	PHYSICAL THERAPY	0	1,118,073	66.00
66.01	03951	CLINICAL NUTRITION	0	222,834	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	470,500	67.00
68.00	06800	SPEECH PATHOLOGY	0	269,612	68.00
69.00	06900	ELECTROCARDIOLOGY	-820,138	809,495	69.00
69.01	06901	CARDIAC REHABILITATION	-31,076	183,906	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-10,200	46,155	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-534,528	7,556,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,321,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,870,624	73.00
74.00	07400	RENAL DIALYSIS	-38,000	528,508	74.00
76.00	03950	ENDOSCOPY	0	127,179	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-532,214	3,559,243	90.00
91.00	09100	EMERGENCY	-1,338,788	2,905,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-28,251,088	149,112,252	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	72,213	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	682,126	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	982,639	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	817,296	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-28,251,088	151,666,526	200.00

RECLASSIFICATIONS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
8/27/2020 2:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - OBSTETRICS RECALSS					
1.00	ADULTS & PEDIATRICS	30.00	671,553	228,176		1.00
2.00	NURSERY	43.00	447,302	119,090		2.00
	TOTALS		1,118,855	347,266		
	B - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	252,140		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	252,140		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	253,967	188,058		1.00
	TOTALS		253,967	188,058		
	H - INSURANCE					
1.00			0	0		1.00
			0	0		
	I - PUMP					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	29,477		1.00
	TOTALS		0	29,477		
	L - MEDICAL PLAZA					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,222,246		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	597,080		2.00
	TOTALS		0	1,819,326		
	N - MEDICAL SUPPLIES & IMPL DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,090,980		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,321,365		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	TOTALS		0	12,412,345		
	O - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,603,061		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	11,603,061		
500.00	Grand Total: Increases		1,372,822	26,651,673		500.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6

Date/Time Prepared:
8/27/2020 2:16 pm

	Decreases						8/27/2020 2:16 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OBSTETRICS RECALSS						
1.00	INTENSIVE CARE UNIT	31.00	231,647	111,055	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	887,208	236,211	0		2.00
	TOTALS		1,118,855	347,266			
	B - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,098	0		1.00
2.00	HOUSEKEEPING	9.00	0	250,022	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,020	0		3.00
	TOTALS		0	252,140			
	E - CAFETERIA						
1.00	DIETARY	10.00	253,967	188,058	0		1.00
	TOTALS		253,967	188,058			
	H - INSURANCE						
1.00			0	0			1.00
			0	0			
	I - PUMP						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,477	0		1.00
	TOTALS		0	29,477			
	L - MEDICAL PLAZA						
1.00	OTHER NRB COST CENTER	194.00	0	1,819,326	10		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,819,326			
	N - MEDICAL SUPPLIES & IMPL DEVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	914,913	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	443,487	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	9,703	0		3.00
4.00	OPERATING ROOM	50.00	0	5,822,089	0		4.00
5.00	RECOVERY ROOM	51.00	0	36,596	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	339,003	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	226,660	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	134,146	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	142,396	0		9.00
10.00	RADIOISOTOPE	56.00	0	11,952	0		10.00
11.00	CT SCAN	57.00	0	59,717	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	25,481	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	2,947,041	0		13.00
14.00	LABORATORY	60.00	0	125,175	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	43,053	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	297,883	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	8,615	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	4,349	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	3,420	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	23,192	0		20.00
21.00	CARDIAC REHABILITATION	69.01	0	1,337	0		21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	121,961	0		22.00
23.00	RENAL DIALYSIS	74.00	0	9,658	0		23.00
24.00	ENDOSCOPY	76.00	0	121,560	0		24.00
25.00	CLINIC	90.00	0	140,160	0		25.00
26.00	EMERGENCY	91.00	0	398,798	0		26.00
	TOTALS		0	12,412,345			
	O - PHARMACY						
1.00	PHARMACY	15.00	0	11,572,269	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,571	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	282	0		3.00
4.00	OPERATING ROOM	50.00	0	8,511	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,283	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,360	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	17	0		7.00
8.00	CT SCAN	57.00	0	540	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	42	0		9.00
10.00	INTRAVENOUS THERAPY	64.00	0	103	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	815	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	22	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	82	0		13.00
14.00	ENDOSCOPY	76.00	0	52	0		14.00
15.00	CLINIC	90.00	0	16,112	0		15.00
	TOTALS		0	11,603,061			
500.00	Grand Total: Decreases		1,372,822	26,651,673			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 2:16 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	632,759	0	0	0	42,508	1.00
2.00	Land Improvements	6,815,977	1,328,624	0	1,328,624	31,004	2.00
3.00	Buildings and Fixtures	158,676,605	890,706	0	890,706	1,006,407	3.00
4.00	Building Improvements	18,108,042	1,736,681	0	1,736,681	0	4.00
5.00	Fixed Equipment	15,370,958	125,155	0	125,155	50,764	5.00
6.00	Movable Equipment	63,062,901	4,290,880	0	4,290,880	2,627,599	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	262,667,242	8,372,046	0	8,372,046	3,758,282	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	262,667,242	8,372,046	0	8,372,046	3,758,282	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	590,251	590,251				1.00
2.00	Land Improvements	8,113,597	8,113,598				2.00
3.00	Buildings and Fixtures	158,560,904	158,560,904				3.00
4.00	Building Improvements	19,844,723	19,844,723				4.00
5.00	Fixed Equipment	15,445,349	15,445,349				5.00
6.00	Movable Equipment	64,726,182	64,726,182				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	267,281,006	267,281,007				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	267,281,006	267,281,007				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/27/2020 2:16 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	7,351,724	0	6,796,978	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,593,533	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,945,257	0	6,796,978	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	14,148,702				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,593,533				2.00
3.00	Total (sum of lines 1-2)	0	19,742,235				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/27/2020 2:16 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	202,554,825	0	202,554,825	0.757835	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	64,726,182	0	64,726,182	0.242165	0	2.00
3.00	Total (sum of lines 1-2)	267,281,007	0	267,281,007	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	5,871,237	1,222,246	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,537,006	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,408,243	1,222,246	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	6,796,978	0	0	0	13,890,461	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-5,112,889	0	0	0	1,424,117	2.00
3.00	Total (sum of lines 1-2)	1,684,089	0	0	0	15,314,578	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 2:16 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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,767,553			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	-9,742,744			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others	B	-706,503	CAFETERIA	11.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-77,367	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,579	MEDICAL RECORDS & LIBRARY	16.00	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	B	-7,763	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-5,536	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
33.00	MISC REVENUE	B	-190,606	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.01	MISC REVENUE	B	-64,934	OPERATION OF PLANT		7.00		0 33.01
33.02	MISC REVENUE	B	-2,296	HOUSEKEEPING		9.00		0 33.02
33.03	MISC REVENUE	B	-2,500	SOCIAL SERVICE		17.00		0 33.03
33.04	MISC REVENUE	B	-413,601	ADULTS & PEDIATRICS		30.00		0 33.04
33.05	MISC REVENUE	B	-2,940	OPERATING ROOM		50.00		0 33.05
33.06	MISC REVENUE	B	-240	DELIVERY ROOM & LABOR ROOM		52.00		0 33.06
33.07	MISC REVENUE	B	-1,453	RADIOLOGY-DIAGNOSTIC		54.00		0 33.07
33.08	MISC REVENUE	B	-560,598	RADIOLOGY-THERAPEUTIC		55.00		0 33.08
33.09	MISC REVENUE	B	-2,615	CT SCAN		57.00		0 33.09
33.10	MISC REVENUE	B	-5,898	MAGNETIC RESONANCE IMAGING (MRI)		58.00		0 33.10
33.11	MISC REVENUE	B	-65,661	LABORATORY		60.00		0 33.11
33.12	MISC REVENUE	B	-1,500	INTRAVENOUS THERAPY		64.00		0 33.12
33.13	MISC REVENUE	B	-13,583	RESPIRATORY THERAPY		65.00		0 33.13
33.14	MISC REVENUE	B	-846	ELECTROCARDIOLOGY		69.00		0 33.14
33.15	MISC REVENUE	B	-17,436	CARDIAC REHABILITATION		69.01		0 33.15
33.16	MISC REVENUE	B	-530,076	CLINIC		90.00		0 33.16
33.17	MISC REVENUE	B	-12,208	EMERGENCY		91.00		0 33.17
33.18	ADVERTISEMENT	A	-17,566	ADMINISTRATIVE & GENERAL		5.00		0 33.18
33.19	ADVERTISEMENT	A	-235	RADIOLOGY-DIAGNOSTIC		54.00		0 33.19
33.20	ADVERTISEMENT	A	-1,173	CLINIC		90.00		0 33.20
33.21	ADVERTISEMENT	A	-669	EMERGENCY		91.00		0 33.21
33.22	RECRUITMENT	A	-87,902	ADMINISTRATIVE & GENERAL		5.00		0 33.22
33.23	RECRUITMENT	A	-110,266	ADULTS & PEDIATRICS		30.00		0 33.23
33.24	LOBBYING	A	-42,570	ADMINISTRATIVE & GENERAL		5.00		0 33.24
33.25	GIFTS	A	-71,855	ADMINISTRATIVE & GENERAL		5.00		0 33.25
33.26	GIFTS	A	-18,342	NURSING ADMINISTRATION		13.00		0 33.26
33.27	GIFTS	A	-273	ADULTS & PEDIATRICS		30.00		0 33.27
33.28	GIFTS	A	-130	INTENSIVE CARE UNIT		31.00		0 33.28
33.29	GIFTS	A	-185	SUBPROVIDER - IRF		41.00		0 33.29
33.30	GIFTS	A	-88	OPERATING ROOM		50.00		0 33.30
33.31	GIFTS	A	-60	DELIVERY ROOM & LABOR ROOM		52.00		0 33.31
33.32	GIFTS	A	-180	RADIOLOGY-THERAPEUTIC		55.00		0 33.32
33.33	GIFTS	A	-369	CARDIAC CATHETERIZATION		59.00		0 33.33
33.34	GIFTS	A	-10	RESPIRATORY THERAPY		65.00		0 33.34
33.35	GIFTS	A	-965	CLINIC		90.00		0 33.35
33.36	GIFTS	A	-2,189	EMERGENCY		91.00		0 33.36
33.37	ENTERTAINMENT	A	-6,667	ADMINISTRATIVE & GENERAL		5.00		0 33.37
33.38	ENTERTAINMENT	A	-269	ELECTROCARDIOLOGY		69.00		0 33.38
33.39	INTEREST REVENUE	A	-1,684,089	CAP REL COSTS-BLDG & FIXT		1.00		9 33.39
33.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.42
33.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.44
33.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.48
33.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.49
33.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.50
33.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.51
33.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.52
33.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.53
33.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.54

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
8/27/2020 2:16 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	
33.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.55
33.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.56
33.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.57
33.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.58
33.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.59
33.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.60
33.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.61
33.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.62
33.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.63
33.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.64
33.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.65
33.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.66
33.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.67
33.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.68
33.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.69
33.70	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,251,088				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 2:16 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	211,365	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	949,009	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	5,112,889
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	24,153,792	21,791,260
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	13,204,551	20,273,596
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	549,188
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-534,528	0
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		37,984,189	47,726,933

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

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

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

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

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

6.00	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: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
8/27/2020 2:16 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		

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

1.00	211,365	9		1.00
2.00	949,009	9		2.00
3.00	-5,112,889	11		3.00
4.00	2,362,532	0		4.00
4.01	-7,069,045	0		4.01
4.02	-549,188	0		4.02
4.03	-534,528	0		4.03
5.00	-9,742,744			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: 14-0046

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

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 2:16 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	6,950	0	6,950	211,500	47	1.00
2.00	17.00	SOCIAL SERVICE	31,648	31,648	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	5,383,938	5,383,938	0	211,500	242	3.00
4.00	31.00	INTENSIVE CARE UNIT	19,750	19,750	0	246,400	57	4.00
5.00	41.00	SUBPROVIDER - IRF	46,167	46,167	0	181,900	180	5.00
6.00	50.00	OPERATING ROOM	628,014	628,014	0	246,400	0	6.00
7.00	53.00	ANESTHESIOLOGY	5,268,205	5,268,205	0	239,400	0	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	-248	-248	0	271,900	0	8.00
9.00	60.00	LABORATORY	160,305	160,305	0	260,300	0	9.00
10.00	65.00	RESPIRATORY THERAPY	23,018	23,018	0	260,300	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	819,023	819,023	0	271,900	622	11.00
12.00	69.01	CARDIAC REHABILITATION	13,640	13,640	0	271,900	30	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	10,200	10,200	0	271,900	68	13.00
14.00	74.00	RENAL DIALYSIS	38,000	38,000	0	197,500	260	14.00
15.00	91.00	EMERGENCY	1,323,722	1,323,722	0	211,500	0	15.00
200.00			13,772,332	13,765,382	6,950		1,506	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	4,779	239	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	24,607	1,230	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	6,752	338	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	15,741	787	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	81,308	4,065	0	0	0	11.00
12.00	69.01	CARDIAC REHABILITATION	3,922	196	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	8,889	444	0	0	0	13.00
14.00	74.00	RENAL DIALYSIS	24,688	1,234	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
200.00			170,686	8,533	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	4,779	2,171	2,171		1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	31,648		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	24,607	0	5,383,938		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	6,752	0	19,750		4.00
5.00	41.00	SUBPROVIDER - IRF	0	15,741	0	46,167		5.00
6.00	50.00	OPERATING ROOM	0	0	0	628,014		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	5,268,205		7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	-248		8.00
9.00	60.00	LABORATORY	0	0	0	160,305		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	23,018		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	81,308	0	819,023		11.00
12.00	69.01	CARDIAC REHABILITATION	0	3,922	0	13,640		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	8,889	0	10,200		13.00
14.00	74.00	RENAL DIALYSIS	0	24,688	0	38,000		14.00
15.00	91.00	EMERGENCY	0	0	0	1,323,722		15.00
200.00			0	170,686	2,171	13,767,553		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 2:16 pm

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	13,890,461	13,890,461				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,424,117		1,424,117			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,629,142	350,915	92	25,980,149		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,172,969	1,871,667	55,554	1,898,010	29,998,200	5.00
7.00	00700	OPERATION OF PLANT	5,289,762	2,222,690	870,363	424,389	8,807,204	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	612,034	153,239	109	55,532	820,914	8.00
9.00	00900	HOUSEKEEPING	1,760,271	357,330	1,689	689,949	2,809,239	9.00
10.00	01000	DIETARY	1,637,593	137,959	980	121,928	1,898,460	10.00
11.00	01100	CAFETERIA	-264,478	360,357	0	448,257	544,136	11.00
13.00	01300	NURSING ADMINISTRATION	1,028,206	68,367	42,688	424,310	1,563,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	648,573	0	2,042	172,475	823,090	14.00
15.00	01500	PHARMACY	2,499,247	121,741	2,418	991,849	3,615,255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	382,289	146,103	43	116,295	644,730	16.00
17.00	01700	SOCIAL SERVICE	1,396,180	125,201	0	521,704	2,043,085	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,476,491	2,020,077	1,994	6,997,138	19,495,700	30.00
31.00	03100	INTENSIVE CARE UNIT	1,961,854	631,157	13,710	878,216	3,484,937	31.00
41.00	04100	SUBPROVIDER - IRF	929,589	325,363	0	432,947	1,687,899	41.00
43.00	04300	NURSERY	566,392	38,598	0	188,498	793,488	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,678,986	1,132,500	75,239	1,175,036	6,061,761	50.00
51.00	05100	RECOVERY ROOM	388,975	0	1,448	185,572	575,995	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,268,223	348,140	9,369	1,029,496	3,655,228	52.00
53.00	05300	ANESTHESIOLOGY	262,963	9,226	3,216	31,670	307,075	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,643,945	806,957	52,190	730,856	3,233,948	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	776,751	0	2,846	560,392	1,339,989	55.00
56.00	05600	RADIOISOTOPE	492,520	0	860	102,626	596,006	56.00
57.00	05700	CT SCAN	540,935	139,004	3,279	236,042	919,260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	310,333	78,241	680	102,514	491,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,074,801	237,319	11,709	448,957	1,772,786	59.00
60.00	06000	LABORATORY	4,867,510	320,210	14,021	1,067,586	6,269,327	60.00
64.00	06400	INTRAVENOUS THERAPY	364,129	48,797	0	176,534	589,460	64.00
65.00	06500	RESPIRATORY THERAPY	1,411,746	53,050	11,978	631,821	2,108,595	65.00
66.00	06600	PHYSICAL THERAPY	1,118,073	134,787	624	537,290	1,790,774	66.00
66.01	03951	CLINICAL NUTRITION	222,834	0	0	107,889	330,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	470,500	124,083	140	226,529	821,252	67.00
68.00	06800	SPEECH PATHOLOGY	269,612	24,543	117	129,697	423,969	68.00
69.00	06900	ELECTROCARDIOLOGY	809,495	631,409	8,571	382,526	1,832,001	69.00
69.01	06901	CARDIAC REHABILITATION	183,906	0	1,853	95,076	280,835	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	46,155	46,815	375	19,967	113,312	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,556,452	0	0	0	7,556,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,321,365	0	0	0	4,321,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,870,624	0	723	601,322	13,472,669	73.00
74.00	07400	RENAL DIALYSIS	528,508	0	375	18,430	547,313	74.00
76.00	03950	ENDOSCOPY	127,179	38,202	16,814	51,623	233,818	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,559,243	114,425	10,555	1,085,128	4,769,351	90.00
91.00	09100	EMERGENCY	2,905,797	561,637	7,868	1,352,683	4,827,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,112,252	13,780,109	1,226,532	25,448,759	148,272,925	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,213	51,284	117	32,362	155,976	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	682,126	13,010	48,621	330,826	1,074,583	192.00
193.00	19300	NONPAID WORKERS	0	0	148,847	168,202	317,049	193.00
194.00	07950	OTHER NRB COST CENTER	982,639	46,058	0	0	1,028,697	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	817,296	0	0	0	817,296	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)	151,666,526	13,890,461	1,424,117	25,980,149	151,666,526	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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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	29,998,200					5.00
7.00	00700	OPERATION OF PLANT	2,171,478	10,978,682				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	202,402	178,119	1,201,435			8.00
9.00	00900	HOUSEKEEPING	692,638	415,345	0	3,917,222		9.00
10.00	01000	DIETARY	468,079	160,357	0	58,140	2,585,036	10.00
11.00	01100	CAFETERIA	134,161	418,864	0	151,866	0	11.00
13.00	01300	NURSING ADMINISTRATION	385,509	79,466	0	28,812	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202,939	0	0	0	0	14.00
15.00	01500	PHARMACY	891,366	141,506	0	51,306	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,963	169,824	0	61,573	0	16.00
17.00	01700	SOCIAL SERVICE	503,737	145,528	0	52,764	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	4,806,822	2,348,052	942,602	851,325	2,028,124	30.00
31.00	03100	INTENSIVE CARE UNIT	859,236	733,630	86,990	265,990	187,170	31.00
41.00	04100	SUBPROVIDER - IRF	416,163	378,188	90,091	137,119	193,842	41.00
43.00	04300	NURSERY	195,640	44,865	81,752	16,267	175,900	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,494,570	1,316,369	0	477,273	0	50.00
51.00	05100	RECOVERY ROOM	142,016	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	901,222	404,663	0	146,718	0	52.00
53.00	05300	ANESTHESIOLOGY	75,711	10,724	0	3,888	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,353	937,972	0	340,078	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	330,384	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	146,949	0	0	0	0	56.00
57.00	05700	CT SCAN	226,650	161,572	0	58,581	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,249	90,944	0	32,973	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	437,093	275,849	0	100,014	0	59.00
60.00	06000	LABORATORY	1,545,746	372,198	0	134,947	0	60.00
64.00	06400	INTRAVENOUS THERAPY	145,335	56,720	0	20,565	0	64.00
65.00	06500	RESPIRATORY THERAPY	519,889	61,663	0	22,357	0	65.00
66.00	06600	PHYSICAL THERAPY	441,528	156,671	0	56,804	0	66.00
66.01	03951	CLINICAL NUTRITION	81,542	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	202,485	144,229	0	52,293	0	67.00
68.00	06800	SPEECH PATHOLOGY	104,533	28,527	0	10,343	0	68.00
69.00	06900	ELECTROCARDIOLOGY	451,693	733,923	0	266,096	0	69.00
69.01	06901	CARDIAC REHABILITATION	69,242	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	27,938	54,416	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,863,096	0	0	19,729	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,065,463	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,321,781	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	134,944	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	57,649	44,404	0	16,099	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,175,917	133,003	0	48,222	0	90.00
91.00	09100	EMERGENCY	1,190,373	652,823	0	236,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		29,161,484	10,850,414	1,201,435	3,718,834	2,585,036	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,457	59,610	0	21,613	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	264,946	15,122	0	5,483	0	192.00
193.00	19300	NONPAID WORKERS	78,171	0	0	171,292	0	193.00
194.00	07950	OTHER NRB COST CENTER	253,632	53,536	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	201,510	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)		29,998,200	10,978,682	1,201,435	3,917,222	2,585,036	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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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	1,249,027					11.00
13.00	01300	NURSING ADMINISTRATION	23,721	2,081,079				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,642	0	1,035,671			14.00
15.00	01500	PHARMACY	55,448	0	8,568	4,763,449		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,501	0	73	0	1,041,664	16.00
17.00	01700	SOCIAL SERVICE	29,165	0	38	40	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	391,187	24,648	122,183	646	65,113	30.00
31.00	03100	INTENSIVE CARE UNIT	49,096	98	60,004	116	10,946	31.00
41.00	04100	SUBPROVIDER - IRF	24,203	144,659	1,315	0	7	41.00
43.00	04300	NURSERY	10,538	183,776	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	65,689	278,266	374,642	3,498	108,621	50.00
51.00	05100	RECOVERY ROOM	10,374	49,570	4,959	0	14,472	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,553	454,087	45,935	528	24,624	52.00
53.00	05300	ANESTHESIOLOGY	1,770	13,625	30,712	0	20,709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,858	7,041	18,144	559	41,060	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,328	72,241	19,103	0	8,610	55.00
56.00	05600	RADIOISOTOPE	5,737	0	1,619	0	19,358	56.00
57.00	05700	CT SCAN	13,196	0	8,092	222	93,777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,731	42	3,453	0	17,634	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,098	75,139	230,291	17	70,871	59.00
60.00	06000	LABORATORY	59,682	106	16,929	0	146,435	60.00
64.00	06400	INTRAVENOUS THERAPY	9,869	65,580	5,834	42	3,702	64.00
65.00	06500	RESPIRATORY THERAPY	35,321	3,039	40,379	335	32,415	65.00
66.00	06600	PHYSICAL THERAPY	30,037	0	1,167	9	13,862	66.00
66.01	03951	CLINICAL NUTRITION	6,031	0	0	0	209	66.01
67.00	06700	OCCUPATIONAL THERAPY	12,664	0	589	0	6,072	67.00
68.00	06800	SPEECH PATHOLOGY	7,251	0	394	0	2,403	68.00
69.00	06900	ELECTROCARDIOLOGY	21,385	154,556	3,135	0	38,045	69.00
69.01	06901	CARDIAC REHABILITATION	5,315	32,456	181	0	1,287	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,116	0	0	0	594	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	24,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,616	169,560	16,526	4,756,635	145,350	73.00
74.00	07400	RENAL DIALYSIS	1,030	0	1,309	0	3,489	74.00
76.00	03950	ENDOSCOPY	2,886	0	0	21	7,898	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60,663	327,844	19,008	663	26,853	90.00
91.00	09100	EMERGENCY	75,620	0	0	118	60,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,219,321	2,056,333	1,034,582	4,763,449	1,041,575	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,494	24,648	1,082	0	89	192.00
193.00	19300	NONPAID WORKERS	9,403	98	7	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	1,249,027	2,081,079	1,035,671	4,763,449	1,041,664	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/27/2020 2:16 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	2,774,357					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,198,202	0	33,274,604	0	33,274,604	30.00
31.00	03100	INTENSIVE CARE UNIT	202,866	0	5,941,079	0	5,941,079	31.00
41.00	04100	SUBPROVIDER - IRF	210,097	0	3,283,583	0	3,283,583	41.00
43.00	04300	NURSERY	0	0	1,502,226	0	1,502,226	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	10,180,689	0	10,180,689	50.00
51.00	05100	RECOVERY ROOM	0	0	797,386	0	797,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,192	0	5,853,750	0	5,853,750	52.00
53.00	05300	ANESTHESIOLOGY	0	0	464,214	0	464,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,417,013	0	5,417,013	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,801,655	0	1,801,655	55.00
56.00	05600	RADIOISOTOPE	0	0	769,669	0	769,669	56.00
57.00	05700	CT SCAN	0	0	1,481,350	0	1,481,350	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	763,794	0	763,794	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,987,158	0	2,987,158	59.00
60.00	06000	LABORATORY	0	0	8,545,370	0	8,545,370	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	897,107	0	897,107	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,823,993	0	2,823,993	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,490,852	0	2,490,852	66.00
66.01	03951	CLINICAL NUTRITION	0	0	418,505	0	418,505	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,239,584	0	1,239,584	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	577,420	0	577,420	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,500,834	0	3,500,834	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	389,316	0	389,316	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	197,376	0	197,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,463,568	0	9,463,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,419,111	0	5,419,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,916,137	0	21,916,137	73.00
74.00	07400	RENAL DIALYSIS	0	0	688,085	0	688,085	74.00
76.00	03950	ENDOSCOPY	0	0	362,775	0	362,775	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	6,561,524	0	6,561,524	90.00
91.00	09100	EMERGENCY	0	0	7,044,196	0	7,044,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,774,357	0	147,053,923	0	147,053,923	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	277,465	0	277,465	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,404,447	0	1,404,447	192.00
193.00	19300	NONPAID WORKERS	0	0	576,020	0	576,020	193.00
194.00	07950	OTHER NRB COST CENTER	0	0	1,335,865	0	1,335,865	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	1,018,806	0	1,018,806	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)	2,774,357	0	151,666,526	0	151,666,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
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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	350,915	92	351,007	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,577	1,871,667	55,554	1,936,798	5.00
7.00	00700	OPERATION OF PLANT	3,306	2,222,690	870,363	3,096,359	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	153,239	109	153,348	8.00
9.00	00900	HOUSEKEEPING	11,028	357,330	1,689	370,047	9.00
10.00	01000	DIETARY	0	137,959	980	138,939	10.00
11.00	01100	CAFETERIA	0	360,357	0	360,357	11.00
13.00	01300	NURSING ADMINISTRATION	0	68,367	42,688	111,055	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,523	0	2,042	45,565	14.00
15.00	01500	PHARMACY	190,708	121,741	2,418	314,867	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	146,103	43	146,146	16.00
17.00	01700	SOCIAL SERVICE	0	125,201	0	125,201	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,417	2,020,077	1,994	2,069,488	30.00
31.00	03100	INTENSIVE CARE UNIT	9,831	631,157	13,710	654,698	31.00
41.00	04100	SUBPROVIDER - IRF	0	325,363	0	325,363	41.00
43.00	04300	NURSERY	0	38,598	0	38,598	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	404,822	1,132,500	75,239	1,612,561	50.00
51.00	05100	RECOVERY ROOM	0	0	1,448	1,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	348,140	9,369	357,509	52.00
53.00	05300	ANESTHESIOLOGY	0	9,226	3,216	12,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,527	806,957	52,190	873,674	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	612	0	2,846	3,458	55.00
56.00	05600	RADIOISOTOPE	0	0	860	860	56.00
57.00	05700	CT SCAN	0	139,004	3,279	142,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,300	78,241	680	152,221	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	237,319	11,709	249,028	59.00
60.00	06000	LABORATORY	0	320,210	14,021	334,231	60.00
64.00	06400	INTRAVENOUS THERAPY	0	48,797	0	48,797	64.00
65.00	06500	RESPIRATORY THERAPY	31,068	53,050	11,978	96,096	65.00
66.00	06600	PHYSICAL THERAPY	128	134,787	624	135,539	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	124,083	140	124,223	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,543	117	24,660	68.00
69.00	06900	ELECTROCARDIOLOGY	0	631,409	8,571	639,980	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	1,853	1,853	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	46,815	375	47,190	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	723	723	73.00
74.00	07400	RENAL DIALYSIS	0	0	375	375	74.00
76.00	03950	ENDOSCOPY	0	38,202	16,814	55,016	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	570,801	114,425	10,555	695,781	90.00
91.00	09100	EMERGENCY	0	561,637	7,868	569,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,410,648	13,780,109	1,226,532	16,417,289	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51,284	117	51,401	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,449	13,010	48,621	97,080	192.00
193.00	19300	NONPAID WORKERS	0	0	148,847	148,847	193.00
194.00	07950	OTHER NRB COST CENTER	1,323,350	46,058	0	1,369,408	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,769,447	13,890,461	1,424,117	18,084,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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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	1,962,443					5.00
7.00	00700	OPERATION OF PLANT	142,051	3,244,144				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,241	52,633	219,972			8.00
9.00	00900	HOUSEKEEPING	45,310	122,732	0	547,411		9.00
10.00	01000	DIETARY	30,620	47,385	0	8,125	226,716	10.00
11.00	01100	CAFETERIA	8,776	123,772	0	21,223	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,219	23,482	0	4,026	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,276	0	0	0	0	14.00
15.00	01500	PHARMACY	58,310	41,814	0	7,170	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,399	50,182	0	8,604	0	16.00
17.00	01700	SOCIAL SERVICE	32,953	43,003	0	7,373	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	314,500	693,835	172,582	118,970	177,873	30.00
31.00	03100	INTENSIVE CARE UNIT	56,209	216,784	15,927	37,171	16,415	31.00
41.00	04100	SUBPROVIDER - IRF	27,224	111,753	16,495	19,162	17,001	41.00
43.00	04300	NURSERY	12,798	13,257	14,968	2,273	15,427	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	97,770	388,980	0	66,696	0	50.00
51.00	05100	RECOVERY ROOM	9,290	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,955	119,576	0	20,503	0	52.00
53.00	05300	ANESTHESIOLOGY	4,953	3,169	0	543	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,160	277,166	0	47,524	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,613	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	9,613	0	0	0	0	56.00
57.00	05700	CT SCAN	14,827	47,744	0	8,186	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,932	26,874	0	4,608	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	28,593	81,512	0	13,976	0	59.00
60.00	06000	LABORATORY	101,118	109,983	0	18,858	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,507	16,760	0	2,874	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,010	18,221	0	3,124	0	65.00
66.00	06600	PHYSICAL THERAPY	28,883	46,295	0	7,938	0	66.00
66.01	03951	CLINICAL NUTRITION	5,334	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	13,246	42,619	0	7,308	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,838	8,430	0	1,445	0	68.00
69.00	06900	ELECTROCARDIOLOGY	29,548	216,870	0	37,186	0	69.00
69.01	06901	CARDIAC REHABILITATION	4,530	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,828	16,080	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	121,878	0	0	2,757	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,699	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	217,301	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,828	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	3,771	13,121	0	2,250	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	76,925	39,302	0	6,739	0	90.00
91.00	09100	EMERGENCY	77,871	192,906	0	33,076	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,907,707	3,206,240	219,972	519,688	226,716	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,516	17,615	0	3,020	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,332	4,469	0	766	0	192.00
193.00	19300	NONPAID WORKERS	5,114	0	0	23,937	0	193.00
194.00	07950	OTHER NRB COST CENTER	16,592	15,820	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	13,182	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)	1,962,443	3,244,144	219,972	547,411	226,716	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
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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	429,286					11.00
13.00	01300	NURSING ADMINISTRATION	8,153	177,668				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,314	0	64,485			14.00
15.00	01500	PHARMACY	19,058	0	534	455,154		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,235	0	5	0	219,142	16.00
17.00	01700	SOCIAL SERVICE	10,024	0	2	4	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	134,437	2,104	7,608	62	13,688	30.00
31.00	03100	INTENSIVE CARE UNIT	16,875	8	3,736	11	2,301	31.00
41.00	04100	SUBPROVIDER - IRF	8,319	12,350	82	0	1	41.00
43.00	04300	NURSERY	3,622	15,689	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,578	23,756	23,326	334	22,835	50.00
51.00	05100	RECOVERY ROOM	3,566	4,232	309	0	3,042	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,781	38,769	2,860	50	5,176	52.00
53.00	05300	ANESTHESIOLOGY	609	1,163	1,912	0	4,354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,043	601	1,130	53	8,632	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,768	6,167	1,189	0	1,810	55.00
56.00	05600	RADIOISOTOPE	1,972	0	101	0	4,069	56.00
57.00	05700	CT SCAN	4,535	0	504	21	19,714	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,970	4	215	0	3,707	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,627	6,415	14,339	2	14,899	59.00
60.00	06000	LABORATORY	20,513	9	1,054	0	30,946	60.00
64.00	06400	INTRAVENOUS THERAPY	3,392	5,599	363	4	778	64.00
65.00	06500	RESPIRATORY THERAPY	12,140	259	2,514	32	6,814	65.00
66.00	06600	PHYSICAL THERAPY	10,324	0	73	1	2,914	66.00
66.01	03951	CLINICAL NUTRITION	2,073	0	0	0	44	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,353	0	37	0	1,276	67.00
68.00	06800	SPEECH PATHOLOGY	2,492	0	25	0	505	68.00
69.00	06900	ELECTROCARDIOLOGY	7,350	13,195	195	0	7,998	69.00
69.01	06901	CARDIAC REHABILITATION	1,827	2,771	11	0	271	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	384	0	0	0	125	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,554	14,476	1,029	454,504	30,556	73.00
74.00	07400	RENAL DIALYSIS	354	0	81	0	733	74.00
76.00	03950	ENDOSCOPY	992	0	0	2	1,660	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	20,850	27,989	1,184	63	5,645	90.00
91.00	09100	EMERGENCY	25,991	0	0	11	12,736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	419,075	175,556	64,418	455,154	219,123	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	622	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,357	2,104	67	0	19	192.00
193.00	19300	NONPAID WORKERS	3,232	8	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	90,899	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	520,185	177,668	64,485	455,154	219,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
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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	225,609					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	178,756		3,978,419	0	3,978,419	30.00
31.00	03100	INTENSIVE CARE UNIT	16,497		1,048,498	0	1,048,498	31.00
41.00	04100	SUBPROVIDER - IRF	17,085		560,685	0	560,685	41.00
43.00	04300	NURSERY	0		119,179	0	119,179	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		2,274,713	0	2,274,713	50.00
51.00	05100	RECOVERY ROOM	0		24,394	0	24,394	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,271		650,360	0	650,360	52.00
53.00	05300	ANESTHESIOLOGY	0		29,573	0	29,573	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,284,858	0	1,284,858	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		52,577	0	52,577	55.00
56.00	05600	RADIOISOTOPE	0		18,002	0	18,002	56.00
57.00	05700	CT SCAN	0		241,003	0	241,003	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		198,916	0	198,916	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		423,457	0	423,457	59.00
60.00	06000	LABORATORY	0		631,137	0	631,137	60.00
64.00	06400	INTRAVENOUS THERAPY	0		90,459	0	90,459	64.00
65.00	06500	RESPIRATORY THERAPY	0		181,747	0	181,747	65.00
66.00	06600	PHYSICAL THERAPY	0		239,227	0	239,227	66.00
66.01	03951	CLINICAL NUTRITION	0		8,909	0	8,909	66.01
67.00	06700	OCCUPATIONAL THERAPY	0		196,123	0	196,123	67.00
68.00	06800	SPEECH PATHOLOGY	0		46,147	0	46,147	68.00
69.00	06900	ELECTROCARDIOLOGY	0		957,491	0	957,491	69.00
69.01	06901	CARDIAC REHABILITATION	0		12,548	0	12,548	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		65,877	0	65,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		129,742	0	129,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		76,486	0	76,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		738,268	0	738,268	73.00
74.00	07400	RENAL DIALYSIS	0		10,620	0	10,620	74.00
76.00	03950	ENDOSCOPY	0		77,510	0	77,510	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		889,140	0	889,140	90.00
91.00	09100	EMERGENCY	0		930,373	0	930,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	225,609	0	16,186,438	0	16,186,438	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		75,611	0	75,611	190.00
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		132,664	0	132,664	192.00
193.00	19300	NONPAID WORKERS	0		183,411	0	183,411	193.00
194.00	07950	OTHER NRB COST CENTER	0		1,401,820	0	1,401,820	194.00
194.01	07951	OTHER NRB COST CENTER	0		0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0		0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0		13,182	0	13,182	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	90,899	0	90,899	201.00
202.00		TOTAL (sum lines 118 through 201)	225,609	0	18,084,025	0	18,084,025	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	385,425					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,777,883				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	822	53,568,107			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,934	498,455	3,913,479	-29,998,200	121,668,326	5.00
7.00	00700	OPERATION OF PLANT	61,674	7,809,352	875,042	0	8,807,204	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	974	114,500	0	820,914	8.00
9.00	00900	HOUSEKEEPING	9,915	15,151	1,422,595	0	2,809,239	9.00
10.00	01000	DIETARY	3,828	8,796	251,402	0	1,898,460	10.00
11.00	01100	CAFETERIA	9,999	0	924,254	0	544,136	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	383,013	874,879	0	1,563,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,325	355,624	0	823,090	14.00
15.00	01500	PHARMACY	3,378	21,692	2,045,078	0	3,615,255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	388	239,786	0	644,730	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	1,075,693	0	2,043,085	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,052	17,894	14,427,322	0	19,495,700	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	123,017	1,810,781	0	3,484,937	31.00
41.00	04100	SUBPROVIDER - IRF	9,028	0	892,688	0	1,687,899	41.00
43.00	04300	NURSERY	1,071	0	388,661	0	793,488	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,424	675,082	2,422,789	0	6,061,761	50.00
51.00	05100	RECOVERY ROOM	0	12,991	382,628	0	575,995	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	84,067	2,122,702	0	3,655,228	52.00
53.00	05300	ANESTHESIOLOGY	256	28,851	65,299	0	307,075	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	468,270	1,506,941	0	3,233,948	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	25,537	1,155,465	0	1,339,989	55.00
56.00	05600	RADIOISOTOPE	0	7,714	211,604	0	596,006	56.00
57.00	05700	CT SCAN	3,857	29,424	486,691	0	919,260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	6,099	211,372	0	491,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	105,060	925,697	0	1,772,786	59.00
60.00	06000	LABORATORY	8,885	125,806	2,201,239	0	6,269,327	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	363,992	0	589,460	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	107,474	1,302,742	0	2,108,595	65.00
66.00	06600	PHYSICAL THERAPY	3,740	5,599	1,107,831	0	1,790,774	66.00
66.01	03951	CLINICAL NUTRITION	0	0	222,454	0	330,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	1,253	467,077	0	821,252	67.00
68.00	06800	SPEECH PATHOLOGY	681	1,048	267,420	0	423,969	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	76,904	788,725	0	1,832,001	69.00
69.01	06901	CARDIAC REHABILITATION	0	16,623	196,036	0	280,835	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	3,365	41,169	0	113,312	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,556,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,321,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,488	1,239,858	0	13,472,669	73.00
74.00	07400	RENAL DIALYSIS	0	3,366	38,000	0	547,313	74.00
76.00	03950	ENDOSCOPY	1,060	150,860	106,440	0	233,818	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,175	94,704	2,237,409	0	4,769,351	90.00
91.00	09100	EMERGENCY	15,584	70,591	2,789,077	0	4,827,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	382,363	11,005,055	52,472,441	-29,998,200	118,274,725	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	1,052	66,726	0	155,976	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	436,251	682,126	0	1,074,583	192.00
193.00	19300	NONPAID WORKERS	0	1,335,525	346,814	0	317,049	193.00
194.00	07950	OTHER NRB COST CENTER	1,278	0	0	0	1,028,697	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	817,296	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)	13,890,461	1,424,117	25,980,149		29,998,200	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.039336	0.111452	0.484993		0.246557	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			351,007		1,962,443	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.006553		0.016129	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: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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	262,080					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	28,672				8.00
9.00	00900	HOUSEKEEPING	9,915	0	257,913			9.00
10.00	01000	DIETARY	3,828	0	3,828	28,672		10.00
11.00	01100	CAFETERIA	9,999	0	9,999	0	46,066,835	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	0	1,897	0	874,879	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	355,624	14.00
15.00	01500	PHARMACY	3,378	0	3,378	0	2,045,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	0	4,054	0	239,786	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	3,474	0	1,075,693	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,052	22,495	56,052	22,495	14,427,322	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	2,076	17,513	2,076	1,810,781	31.00
41.00	04100	SUBPROVIDER - IRF	9,028	2,150	9,028	2,150	892,688	41.00
43.00	04300	NURSERY	1,071	1,951	1,071	1,951	388,661	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,424	0	31,424	0	2,422,789	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	382,628	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	0	9,660	0	2,122,702	52.00
53.00	05300	ANESTHESIOLOGY	256	0	256	0	65,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	0	22,391	0	1,506,941	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	1,155,465	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	211,604	56.00
57.00	05700	CT SCAN	3,857	0	3,857	0	486,691	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	0	2,171	0	211,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	0	6,585	0	925,697	59.00
60.00	06000	LABORATORY	8,885	0	8,885	0	2,201,239	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	1,354	0	363,992	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	0	1,472	0	1,302,742	65.00
66.00	06600	PHYSICAL THERAPY	3,740	0	3,740	0	1,107,831	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	222,454	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	0	3,443	0	467,077	67.00
68.00	06800	SPEECH PATHOLOGY	681	0	681	0	267,420	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	0	17,520	0	788,725	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	196,036	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	0	0	0	41,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,299	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	1,239,858	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	38,000	74.00
76.00	03950	ENDOSCOPY	1,060	0	1,060	0	106,440	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,175	0	3,175	0	2,237,409	90.00
91.00	09100	EMERGENCY	15,584	0	15,584	0	2,789,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,018	28,672	244,851	28,672	44,971,169	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	0	1,423	0	66,726	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	0	361	0	682,126	192.00
193.00	19300	NONPAID WORKERS	0	0	11,278	0	346,814	193.00
194.00	07950	OTHER NRB COST CENTER	1,278	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	10,978,682	1,201,435	3,917,222	2,585,036	1,249,027	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.890575	41.902727	15.188153	90.158901	0.027113	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,244,144	219,972	547,411	226,716	520,185	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.378449	7.672015	2.122464	7.907227	0.009319	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			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	295,851					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,643,336				14.00
15.00	01500	PHARMACY	0	63,235	11,589,327			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	539	0	548,838,243		16.00
17.00	01700	SOCIAL SERVICE	0	281	98	0	28,391	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,504	901,723	1,571	34,306,187	22,495	30.00
31.00	03100	INTENSIVE CARE UNIT	14	442,832	282	5,767,056	2,076	31.00
41.00	04100	SUBPROVIDER - IRF	20,565	9,703	0	3,504	2,150	41.00
43.00	04300	NURSERY	26,126	0	0	14	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,559	2,764,892	8,511	57,229,345	0	50.00
51.00	05100	RECOVERY ROOM	7,047	36,595	0	7,624,846	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,554	339,002	1,284	12,973,462	1,670	52.00
53.00	05300	ANESTHESIOLOGY	1,937	226,660	0	10,911,152	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,001	133,903	1,360	21,633,491	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,270	140,980	0	4,536,556	0	55.00
56.00	05600	RADIOISOTOPE	0	11,952	0	10,199,240	0	56.00
57.00	05700	CT SCAN	0	59,717	540	49,408,431	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6	25,481	0	9,290,727	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,682	1,699,567	42	37,339,857	0	59.00
60.00	06000	LABORATORY	15	124,939	0	77,168,327	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,323	43,053	102	1,950,477	0	64.00
65.00	06500	RESPIRATORY THERAPY	432	298,002	815	17,078,271	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,615	22	7,303,335	0	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	109,982	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	4,349	0	3,199,066	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,910	0	1,266,197	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,972	23,137	0	20,044,897	0	69.00
69.01	06901	CARDIAC REHABILITATION	4,614	1,337	0	678,090	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	312,742	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,798,346	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,008,835	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,105	121,962	11,572,749	76,580,650	0	73.00
74.00	07400	RENAL DIALYSIS	0	9,658	0	1,838,172	0	74.00
76.00	03950	ENDOSCOPY	0	0	52	4,161,420	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	46,607	140,281	1,612	14,148,236	0	90.00
91.00	09100	EMERGENCY	0	0	287	31,920,646	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	292,333	7,635,305	11,589,327	548,791,557	28,391	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	3,504	7,982	0	46,686	0	192.00
193.00	19300	NONPAID WORKERS	14	49	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	2,081,079	1,035,671	4,763,449	1,041,664	2,774,357	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.034213	0.135500	0.411020	0.001898	97.719594	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	177,668	64,485	455,154	219,142	225,609	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.600532	0.008437	0.039274	0.000399	7.946497	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
206.00		13.00	14.00	15.00	16.00	17.00	206.00
207.00	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 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	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		55.00
56.00	05600	RADIOISOTOPE	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
66.01	03951	CLINICAL NUTRITION	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
69.01	06901	CARDIAC REHABILITATION	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	ENDOSCOPY	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0		118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	OTHER NRB COST CENTER	0		194.00
194.01	07951	OTHER NRB COST CENTER	0		194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0		194.02
194.03	07953	RETAIL PHARMACY	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)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
8/27/2020 2:16 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

Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 pm

MCRIF32 - 16.2.168.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,551,530		34,551,530		30.00
31.00	03100	INTENSIVE CARE UNIT	5,750,685		5,750,685		31.00
41.00	04100	SUBPROVIDER - IRF	2,705,390		2,705,390		41.00
43.00	04300	NURSERY	2,421,865		2,421,865		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,219,133	32,345,452	59,564,585	0.170918	0.000000
51.00	05100	RECOVERY ROOM	3,607,379	4,284,746	7,892,125	0.101036	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,743,329	2,782,354	13,525,683	0.432788	0.000000
53.00	05300	ANESTHESIOLOGY	6,092,306	5,234,679	11,326,985	0.040983	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,398,715	15,736,338	22,135,053	0.244726	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	712,310	3,854,380	4,566,690	0.394521	0.000000
56.00	05600	RADIOISOTOPE	1,964,755	8,434,595	10,399,350	0.074011	0.000000
57.00	05700	CT SCAN	13,839,395	36,492,224	50,331,619	0.029432	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,686,129	7,879,939	9,566,068	0.079844	0.000000
59.00	05900	CARDIAC CATHETERIZATION	20,209,605	17,555,012	37,764,617	0.079099	0.000000
60.00	06000	LABORATORY	35,078,230	43,339,284	78,417,514	0.108973	0.000000
64.00	06400	INTRAVENOUS THERAPY	615	2,035,240	2,035,855	0.440654	0.000000
65.00	06500	RESPIRATORY THERAPY	14,122,810	3,031,809	17,154,619	0.164620	0.000000
66.00	06600	PHYSICAL THERAPY	4,735,117	2,790,122	7,525,239	0.331000	0.000000
66.01	03951	CLINICAL NUTRITION	0	110,310	110,310	3.793899	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,404,551	817,655	3,222,206	0.384700	0.000000
68.00	06800	SPEECH PATHOLOGY	646,191	651,222	1,297,413	0.445055	0.000000
69.00	06900	ELECTROCARDIOLOGY	8,616,327	11,802,099	20,418,426	0.171455	0.000000
69.01	06901	CARDIAC REHABILITATION	39,825	647,230	687,055	0.566645	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	273,050	39,930	312,980	0.630635	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,535,196	4,215,202	12,750,398	0.742217	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,640,724	7,304,389	16,945,113	0.319804	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	31,039,720	45,314,709	76,354,429	0.287032	0.000000
74.00	07400	RENAL DIALYSIS	1,737,655	100,280	1,837,935	0.374379	0.000000
76.00	03950	ENDOSCOPY	868,620	3,467,235	4,335,855	0.083669	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	42,581	11,604,248	11,646,829	0.563374	0.000000
91.00	09100	EMERGENCY	7,749,802	25,281,493	33,031,295	0.213258	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	331,761	1,875,547	2,207,308	1.185054	0.000000
200.00		Subtotal (see instructions)	263,765,301	299,027,723	562,793,024		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	263,765,301	299,027,723	562,793,024		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 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
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170918			50.00
51.00	05100	RECOVERY ROOM	0.101036			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.432788			52.00
53.00	05300	ANESTHESIOLOGY	0.040983			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244726			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.394521			55.00
56.00	05600	RADIOISOTOPE	0.074011			56.00
57.00	05700	CT SCAN	0.029432			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079844			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079099			59.00
60.00	06000	LABORATORY	0.108973			60.00
64.00	06400	INTRAVENOUS THERAPY	0.440654			64.00
65.00	06500	RESPIRATORY THERAPY	0.164620			65.00
66.00	06600	PHYSICAL THERAPY	0.331000			66.00
66.01	03951	CLINICAL NUTRITION	3.793899			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.384700			67.00
68.00	06800	SPEECH PATHOLOGY	0.445055			68.00
69.00	06900	ELECTROCARDIOLOGY	0.171455			69.00
69.01	06901	CARDIAC REHABILITATION	0.566645			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.630635			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.742217			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319804			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287032			73.00
74.00	07400	RENAL DIALYSIS	0.374379			74.00
76.00	03950	ENDOSCOPY	0.083669			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.563374			90.00
91.00	09100	EMERGENCY	0.213258			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.185054			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,274,604		33,274,604	0	33,274,604	30.00
31.00	03100	INTENSIVE CARE UNIT	5,941,079		5,941,079	0	5,941,079	31.00
41.00	04100	SUBPROVIDER - IRF	3,283,583		3,283,583	0	3,283,583	41.00
43.00	04300	NURSERY	1,502,226		1,502,226	0	1,502,226	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,180,689		10,180,689	0	10,180,689	50.00
51.00	05100	RECOVERY ROOM	797,386		797,386	0	797,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,853,750		5,853,750	0	5,853,750	52.00
53.00	05300	ANESTHESIOLOGY	464,214		464,214	0	464,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,417,013		5,417,013	0	5,417,013	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,801,655		1,801,655	0	1,801,655	55.00
56.00	05600	RADIOISOTOPE	769,669		769,669	0	769,669	56.00
57.00	05700	CT SCAN	1,481,350		1,481,350	0	1,481,350	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,794		763,794	0	763,794	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,987,158		2,987,158	0	2,987,158	59.00
60.00	06000	LABORATORY	8,545,370		8,545,370	0	8,545,370	60.00
64.00	06400	INTRAVENOUS THERAPY	897,107		897,107	0	897,107	64.00
65.00	06500	RESPIRATORY THERAPY	2,823,993	0	2,823,993	0	2,823,993	65.00
66.00	06600	PHYSICAL THERAPY	2,490,852	0	2,490,852	0	2,490,852	66.00
66.01	03951	CLINICAL NUTRITION	418,505	0	418,505	0	418,505	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,239,584	0	1,239,584	0	1,239,584	67.00
68.00	06800	SPEECH PATHOLOGY	577,420	0	577,420	0	577,420	68.00
69.00	06900	ELECTROCARDIOLOGY	3,500,834		3,500,834	0	3,500,834	69.00
69.01	06901	CARDIAC REHABILITATION	389,316		389,316	0	389,316	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	197,376		197,376	0	197,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,463,568		9,463,568	0	9,463,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,419,111		5,419,111	0	5,419,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,916,137		21,916,137	0	21,916,137	73.00
74.00	07400	RENAL DIALYSIS	688,085		688,085	0	688,085	74.00
76.00	03950	ENDOSCOPY	362,775		362,775	0	362,775	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,561,524		6,561,524	0	6,561,524	90.00
91.00	09100	EMERGENCY	7,044,196		7,044,196	0	7,044,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,615,779		2,615,779	0	2,615,779	92.00
200.00		Subtotal (see instructions)	149,669,702	0	149,669,702	0	149,669,702	200.00
201.00		Less Observation Beds	2,615,779		2,615,779	0	2,615,779	201.00
202.00		Total (see instructions)	147,053,923	0	147,053,923	0	147,053,923	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,551,530		34,551,530		30.00
31.00	03100	INTENSIVE CARE UNIT	5,750,685		5,750,685		31.00
41.00	04100	SUBPROVIDER - IRF	2,705,390		2,705,390		41.00
43.00	04300	NURSERY	2,421,865		2,421,865		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,219,133	32,345,452	59,564,585	0.170918	0.000000
51.00	05100	RECOVERY ROOM	3,607,379	4,284,746	7,892,125	0.101036	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,743,329	2,782,354	13,525,683	0.432788	0.000000
53.00	05300	ANESTHESIOLOGY	6,092,306	5,234,679	11,326,985	0.040983	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,398,715	15,736,338	22,135,053	0.244726	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	712,310	3,854,380	4,566,690	0.394521	0.000000
56.00	05600	RADIOISOTOPE	1,964,755	8,434,595	10,399,350	0.074011	0.000000
57.00	05700	CT SCAN	13,839,395	36,492,224	50,331,619	0.029432	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,686,129	7,879,939	9,566,068	0.079844	0.000000
59.00	05900	CARDIAC CATHETERIZATION	20,209,605	17,555,012	37,764,617	0.079099	0.000000
60.00	06000	LABORATORY	35,078,230	43,339,284	78,417,514	0.108973	0.000000
64.00	06400	INTRAVENOUS THERAPY	615	2,035,240	2,035,855	0.440654	0.000000
65.00	06500	RESPIRATORY THERAPY	14,122,810	3,031,809	17,154,619	0.164620	0.000000
66.00	06600	PHYSICAL THERAPY	4,735,117	2,790,122	7,525,239	0.331000	0.000000
66.01	03951	CLINICAL NUTRITION	0	110,310	110,310	3.793899	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,404,551	817,655	3,222,206	0.384700	0.000000
68.00	06800	SPEECH PATHOLOGY	646,191	651,222	1,297,413	0.445055	0.000000
69.00	06900	ELECTROCARDIOLOGY	8,616,327	11,802,099	20,418,426	0.171455	0.000000
69.01	06901	CARDIAC REHABILITATION	39,825	647,230	687,055	0.566645	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	273,050	39,930	312,980	0.630635	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,535,196	4,215,202	12,750,398	0.742217	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,640,724	7,304,389	16,945,113	0.319804	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	31,039,720	45,314,709	76,354,429	0.287032	0.000000
74.00	07400	RENAL DIALYSIS	1,737,655	100,280	1,837,935	0.374379	0.000000
76.00	03950	ENDOSCOPY	868,620	3,467,235	4,335,855	0.083669	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	42,581	11,604,248	11,646,829	0.563374	0.000000
91.00	09100	EMERGENCY	7,749,802	25,281,493	33,031,295	0.213258	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	331,761	1,875,547	2,207,308	1.185054	0.000000
200.00		Subtotal (see instructions)	263,765,301	299,027,723	562,793,024		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	263,765,301	299,027,723	562,793,024		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/27/2020 2:16 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
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.170918			50.00
51.00	05100	RECOVERY ROOM	0.101036			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.432788			52.00
53.00	05300	ANESTHESIOLOGY	0.040983			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244726			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.394521			55.00
56.00	05600	RADIOISOTOPE	0.074011			56.00
57.00	05700	CT SCAN	0.029432			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079844			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079099			59.00
60.00	06000	LABORATORY	0.108973			60.00
64.00	06400	INTRAVENOUS THERAPY	0.440654			64.00
65.00	06500	RESPIRATORY THERAPY	0.164620			65.00
66.00	06600	PHYSICAL THERAPY	0.331000			66.00
66.01	03951	CLINICAL NUTRITION	3.793899			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.384700			67.00
68.00	06800	SPEECH PATHOLOGY	0.445055			68.00
69.00	06900	ELECTROCARDIOLOGY	0.171455			69.00
69.01	06901	CARDIAC REHABILITATION	0.566645			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.630635			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.742217			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319804			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287032			73.00
74.00	07400	RENAL DIALYSIS	0.374379			74.00
76.00	03950	ENDOSCOPY	0.083669			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.563374			90.00
91.00	09100	EMERGENCY	0.213258			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.185054			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/27/2020 2:16 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	10,180,689	2,274,713	7,905,976	0	0
51.00	05100	RECOVERY ROOM	797,386	24,394	772,992	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,853,750	650,360	5,203,390	0	0
53.00	05300	ANESTHESIOLOGY	464,214	29,573	434,641	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,417,013	1,284,858	4,132,155	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	1,801,655	52,577	1,749,078	0	0
56.00	05600	RADIOISOTOPE	769,669	18,002	751,667	0	0
57.00	05700	CT SCAN	1,481,350	241,003	1,240,347	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,794	198,916	564,878	0	0
59.00	05900	CARDIAC CATHETERIZATION	2,987,158	423,457	2,563,701	0	0
60.00	06000	LABORATORY	8,545,370	631,137	7,914,233	0	0
64.00	06400	INTRAVENOUS THERAPY	897,107	90,459	806,648	0	0
65.00	06500	RESPIRATORY THERAPY	2,823,993	181,747	2,642,246	0	0
66.00	06600	PHYSICAL THERAPY	2,490,852	239,227	2,251,625	0	0
66.01	03951	CLINICAL NUTRITION	418,505	8,909	409,596	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,239,584	196,123	1,043,461	0	0
68.00	06800	SPEECH PATHOLOGY	577,420	46,147	531,273	0	0
69.00	06900	ELECTROCARDIOLOGY	3,500,834	957,491	2,543,343	0	0
69.01	06901	CARDIAC REHABILITATION	389,316	12,548	376,768	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	197,376	65,877	131,499	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,463,568	129,742	9,333,826	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,419,111	76,486	5,342,625	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	21,916,137	738,268	21,177,869	0	0
74.00	07400	RENAL DIALYSIS	688,085	10,620	677,465	0	0
76.00	03950	ENDOSCOPY	362,775	77,510	285,265	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,561,524	889,140	5,672,384	0	0
91.00	09100	EMERGENCY	7,044,196	930,373	6,113,823	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,615,779	312,750	2,303,029	0	0
200.00		Subtotal (sum of lines 50 thru 199)	105,668,210	10,792,407	94,875,803	0	0
201.00		Less Observation Beds	2,615,779	312,750	2,303,029	0	0
202.00		Total (line 200 minus line 201)	103,052,431	10,479,657	92,572,774	0	0

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

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/27/2020 2:16 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	10,180,689	59,564,585	0.170918	50.00
51.00	05100	RECOVERY ROOM	797,386	7,892,125	0.101036	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,853,750	13,525,683	0.432788	52.00
53.00	05300	ANESTHESIOLOGY	464,214	11,326,985	0.040983	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,417,013	22,135,053	0.244726	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,801,655	4,566,690	0.394521	55.00
56.00	05600	RADIOISOTOPE	769,669	10,399,350	0.074011	56.00
57.00	05700	CT SCAN	1,481,350	50,331,619	0.029432	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	763,794	9,566,068	0.079844	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,987,158	37,764,617	0.079099	59.00
60.00	06000	LABORATORY	8,545,370	78,417,514	0.108973	60.00
64.00	06400	INTRAVENOUS THERAPY	897,107	2,035,855	0.440654	64.00
65.00	06500	RESPIRATORY THERAPY	2,823,993	17,154,619	0.164620	65.00
66.00	06600	PHYSICAL THERAPY	2,490,852	7,525,239	0.331000	66.00
66.01	03951	CLINICAL NUTRITION	418,505	110,310	3.793899	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,239,584	3,222,206	0.384700	67.00
68.00	06800	SPEECH PATHOLOGY	577,420	1,297,413	0.445055	68.00
69.00	06900	ELECTROCARDIOLOGY	3,500,834	20,418,426	0.171455	69.00
69.01	06901	CARDIAC REHABILITATION	389,316	687,055	0.566645	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	197,376	312,980	0.630635	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,463,568	12,750,398	0.742217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,419,111	16,945,113	0.319804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,916,137	76,354,429	0.287032	73.00
74.00	07400	RENAL DIALYSIS	688,085	1,837,935	0.374379	74.00
76.00	03950	ENDOSCOPY	362,775	4,335,855	0.083669	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,561,524	11,646,829	0.563374	90.00
91.00	09100	EMERGENCY	7,044,196	33,031,295	0.213258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,615,779	2,207,308	1.185054	92.00
200.00		Subtotal (sum of lines 50 thru 199)	105,668,210	517,363,554		200.00
201.00		Less Observation Beds	2,615,779	0		201.00
202.00		Total (line 200 minus line 201)	103,052,431	517,363,554		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 2:16 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	3,978,419	0	3,978,419	25,734	154.60	30.00
31.00	INTENSIVE CARE UNIT	1,048,498		1,048,498	2,076	505.06	31.00
41.00	SUBPROVIDER - IRF	560,685	0	560,685	2,150	260.78	41.00
43.00	NURSERY	119,179		119,179	1,951	61.09	43.00
200.00	Total (lines 30 through 199)	5,706,781		5,706,781	31,911		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	13,313	2,058,190				
31.00	INTENSIVE CARE UNIT	1,220	616,173				
41.00	SUBPROVIDER - IRF	1,613	420,638				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	16,146	3,095,001				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 2:16 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	2,274,713	59,564,585	0.038189	18,974,313	724,610	50.00
51.00	05100	RECOVERY ROOM	24,394	7,892,125	0.003091	1,909,321	5,902	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	650,360	13,525,683	0.048083	6,900	332	52.00
53.00	05300	ANESTHESIOLOGY	29,573	11,326,985	0.002611	2,652,365	6,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,284,858	22,135,053	0.058046	2,815,095	163,405	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	52,577	4,566,690	0.011513	700	8	55.00
56.00	05600	RADIOISOTOPE	18,002	10,399,350	0.001731	1,221,740	2,115	56.00
57.00	05700	CT SCAN	241,003	50,331,619	0.004788	7,669,385	36,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198,916	9,566,068	0.020794	798,925	16,613	58.00
59.00	05900	CARDIAC CATHETERIZATION	423,457	37,764,617	0.011213	7,429,800	83,310	59.00
60.00	06000	LABORATORY	631,137	78,417,514	0.008048	18,117,485	145,810	60.00
64.00	06400	INTRAVENOUS THERAPY	90,459	2,035,855	0.044433	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,747	17,154,619	0.010595	8,575,030	90,852	65.00
66.00	06600	PHYSICAL THERAPY	239,227	7,525,239	0.031790	2,370,951	75,373	66.00
66.01	03951	CLINICAL NUTRITION	8,909	110,310	0.080763	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,123	3,222,206	0.060866	703,506	42,820	67.00
68.00	06800	SPEECH PATHOLOGY	46,147	1,297,413	0.035568	182,790	6,501	68.00
69.00	06900	ELECTROCARDIOLOGY	957,491	20,418,426	0.046893	6,052,220	283,807	69.00
69.01	06901	CARDIAC REHABILITATION	12,548	687,055	0.018263	20,945	383	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	65,877	312,980	0.210483	164,757	34,679	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,742	12,750,398	0.010176	5,098,865	51,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,486	16,945,113	0.004514	5,903,454	26,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	738,268	76,354,429	0.009669	16,679,200	161,271	73.00
74.00	07400	RENAL DIALYSIS	10,620	1,837,935	0.005778	1,217,690	7,036	74.00
76.00	03950	ENDOSCOPY	77,510	4,335,855	0.017877	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	889,140	11,646,829	0.076342	1,475	113	90.00
91.00	09100	EMERGENCY	930,373	33,031,295	0.028166	4,505,632	126,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	312,750	2,207,308	0.141688	233,709	33,114	92.00
200.00		Total (lines 50 through 199)	10,792,407	517,363,554		113,306,253	2,127,140	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 2:16 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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	25,734	0.00	13,313	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	2,076	0.00	1,220	31.00			
41.00	04100	SUBPROVIDER - IRF	0	0	2,150	0.00	1,613	41.00			
43.00	04300	NURSERY	0	0	1,951	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	31,911		16,146	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	
41.00	04100	SUBPROVIDER - IRF	0							41.00	
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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:16 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	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
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: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 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	59,564,585	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,892,125	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,525,683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,326,985	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,135,053	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,566,690	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,399,350	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,331,619	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,566,068	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,764,617	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	78,417,514	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,035,855	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,154,619	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,525,239	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	110,310	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,222,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,297,413	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,418,426	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	687,055	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	312,980	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,750,398	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,945,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,354,429	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,837,935	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	4,335,855	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,646,829	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,031,295	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,207,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	517,363,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:16 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	18,974,313	0	15,599,139	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,909,321	0	3,003,085	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	6,900	0	6,240	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,652,365	0	2,367,115	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,815,095	0	5,720,680	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	700	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,221,740	0	4,633,230	0	56.00
57.00	05700	CT SCAN	0.000000	7,669,385	0	14,864,695	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	798,925	0	3,237,985	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	7,429,800	0	6,952,225	0	59.00
60.00	06000	LABORATORY	0.000000	18,117,485	0	10,144,512	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	749,375	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	8,575,030	0	1,311,295	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,370,951	0	38,535	0	66.00
66.01	03951	CLINICAL NUTRITION	0.000000	0	0	2,770	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	703,506	0	11,810	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	182,790	0	6,732	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,052,220	0	7,100,012	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	20,945	0	392,350	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	164,757	0	18,780	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,098,865	0	2,325,145	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,903,454	0	5,032,538	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,679,200	0	25,070,380	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,217,690	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	0	0	75,210	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	1,475	0	73,020	0	90.00
91.00	09100	EMERGENCY	0.000000	4,505,632	0	11,243,344	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	233,709	0	801,898	0	92.00
200.00		Total (lines 50 through 199)		113,306,253	0	120,782,100	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 2:16 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	0.170918	15,599,139	0	0	2,666,174	50.00	
51.00	05100	RECOVERY ROOM	0.101036	3,003,085	0	0	303,420	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.432788	6,240	0	0	2,701	52.00	
53.00	05300	ANESTHESIOLOGY	0.040983	2,367,115	0	0	97,011	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244726	5,720,680	0	0	1,399,999	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.394521	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.074011	4,633,230	0	0	342,910	56.00	
57.00	05700	CT SCAN	0.029432	14,864,695	0	0	437,498	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079844	3,237,985	0	0	258,534	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.079099	6,952,225	0	0	549,914	59.00	
60.00	06000	LABORATORY	0.108973	10,144,512	0	0	1,105,478	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.440654	749,375	0	0	330,215	64.00	
65.00	06500	RESPIRATORY THERAPY	0.164620	1,311,295	0	0	215,865	65.00	
66.00	06600	PHYSICAL THERAPY	0.331000	38,535	0	0	12,755	66.00	
66.01	03951	CLINICAL NUTRITION	3.793899	2,770	0	0	10,509	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.384700	11,810	0	0	4,543	67.00	
68.00	06800	SPEECH PATHOLOGY	0.445055	6,732	0	0	2,996	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.171455	7,100,012	0	0	1,217,333	69.00	
69.01	06901	CARDIAC REHABILITATION	0.566645	392,350	0	0	222,323	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.630635	18,780	0	0	11,843	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.742217	2,325,145	0	0	1,725,762	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319804	5,032,538	0	0	1,609,426	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287032	25,070,380	0	116,319	7,196,001	73.00	
74.00	07400	RENAL DIALYSIS	0.374379	0	0	0	0	74.00	
76.00	03950	ENDOSCOPY	0.083669	75,210	0	0	6,293	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.563374	73,020	0	0	41,138	90.00	
91.00	09100	EMERGENCY	0.213258	11,243,344	0	0	2,397,733	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.185054	801,898	0	0	950,292	92.00	
200.00		Subtotal (see instructions)		120,782,100	0	116,319	23,118,666	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		120,782,100	0	116,319	23,118,666	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/27/2020 2:16 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	03951	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	06901	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	33,387		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	0	0		76.00
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	33,387		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	33,387		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/27/2020 2:16 pm		
				Component CCN: 14-T046				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,274,713	59,564,585	0.038189	10,265	392	50.00
51.00	05100	RECOVERY ROOM	24,394	7,892,125	0.003091	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	650,360	13,525,683	0.048083	0	0	52.00
53.00	05300	ANESTHESIOLOGY	29,573	11,326,985	0.002611	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,284,858	22,135,053	0.058046	29,705	1,724	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	52,577	4,566,690	0.011513	0	0	55.00
56.00	05600	RADIOISOTOPE	18,002	10,399,350	0.001731	3,170	5	56.00
57.00	05700	CT SCAN	241,003	50,331,619	0.004788	35,785	171	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198,916	9,566,068	0.020794	6,150	128	58.00
59.00	05900	CARDIAC CATHETERIZATION	423,457	37,764,617	0.011213	0	0	59.00
60.00	06000	LABORATORY	631,137	78,417,514	0.008048	229,201	1,845	60.00
64.00	06400	INTRAVENOUS THERAPY	90,459	2,035,855	0.044433	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,747	17,154,619	0.010595	178,970	1,896	65.00
66.00	06600	PHYSICAL THERAPY	239,227	7,525,239	0.031790	1,863,010	59,225	66.00
66.01	03951	CLINICAL NUTRITION	8,909	110,310	0.080763	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,123	3,222,206	0.060866	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,147	1,297,413	0.035568	245,300	8,725	68.00
69.00	06900	ELECTROCARDIOLOGY	957,491	20,418,426	0.046893	14,195	666	69.00
69.01	06901	CARDIAC REHABILITATION	12,548	687,055	0.018263	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	65,877	312,980	0.210483	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,742	12,750,398	0.010176	73,150	744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,486	16,945,113	0.004514	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	738,268	76,354,429	0.009669	293,860	2,841	73.00
74.00	07400	RENAL DIALYSIS	10,620	1,837,935	0.005778	39,830	230	74.00
76.00	03950	ENDOSCOPY	77,510	4,335,855	0.017877	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	889,140	11,646,829	0.076342	65	5	90.00
91.00	09100	EMERGENCY	930,373	33,031,295	0.028166	266,880	7,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,207,308	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	10,479,657	517,363,554		3,289,536	86,114	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	59,564,585	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,892,125	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,525,683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,326,985	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,135,053	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,566,690	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,399,350	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,331,619	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,566,068	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,764,617	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	78,417,514	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,035,855	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,154,619	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,525,239	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	110,310	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,222,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,297,413	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,418,426	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	687,055	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	312,980	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,750,398	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,945,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,354,429	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,837,935	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	4,335,855	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,646,829	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,031,295	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,207,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	517,363,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		10,265	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		29,705	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		3,170	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		35,785	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		6,150	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		229,201	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		178,970	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		1,863,010	0	0	0	66.00
66.01	03951	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		245,300	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		14,195	0	0	0	69.00
69.01	06901	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		73,150	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		293,860	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		39,830	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000		0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		65	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		266,880	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)			3,289,536	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/27/2020 2:16 pm

Title XIX			Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,978,419	0	3,978,419	25,734	154.60	30.00
31.00	INTENSIVE CARE UNIT	1,048,498		1,048,498	2,076	505.06	31.00
41.00	SUBPROVIDER - IRF	560,685	0	560,685	2,150	260.78	41.00
43.00	NURSERY	119,179		119,179	1,951	61.09	43.00
200.00	Total (lines 30 through 199)	5,706,781		5,706,781	31,911		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	633	97,862				
31.00	INTENSIVE CARE UNIT	169	85,355				
41.00	SUBPROVIDER - IRF	74	19,298				
43.00	NURSERY	430	26,269				
200.00	Total (lines 30 through 199)	1,306	228,784				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/27/2020 2:16 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	2,274,713	59,564,585	0.038189	0	0 50.00
51.00	05100	RECOVERY ROOM	24,394	7,892,125	0.003091	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	650,360	13,525,683	0.048083	0	0 52.00
53.00	05300	ANESTHESIOLOGY	29,573	11,326,985	0.002611	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,284,858	22,135,053	0.058046	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	52,577	4,566,690	0.011513	0	0 55.00
56.00	05600	RADIOISOTOPE	18,002	10,399,350	0.001731	0	0 56.00
57.00	05700	CT SCAN	241,003	50,331,619	0.004788	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198,916	9,566,068	0.020794	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	423,457	37,764,617	0.011213	0	0 59.00
60.00	06000	LABORATORY	631,137	78,417,514	0.008048	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	90,459	2,035,855	0.044433	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	181,747	17,154,619	0.010595	0	0 65.00
66.00	06600	PHYSICAL THERAPY	239,227	7,525,239	0.031790	0	0 66.00
66.01	03951	CLINICAL NUTRITION	8,909	110,310	0.080763	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	196,123	3,222,206	0.060866	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	46,147	1,297,413	0.035568	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	957,491	20,418,426	0.046893	0	0 69.00
69.01	06901	CARDIAC REHABILITATION	12,548	687,055	0.018263	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	65,877	312,980	0.210483	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,742	12,750,398	0.010176	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,486	16,945,113	0.004514	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	738,268	76,354,429	0.009669	0	0 73.00
74.00	07400	RENAL DIALYSIS	10,620	1,837,935	0.005778	0	0 74.00
76.00	03950	ENDOSCOPY	77,510	4,335,855	0.017877	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	889,140	11,646,829	0.076342	0	0 90.00
91.00	09100	EMERGENCY	930,373	33,031,295	0.028166	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	312,750	2,207,308	0.141688	0	0 92.00
200.00		Total (lines 50 through 199)	10,792,407	517,363,554		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/27/2020 2:16 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
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
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	25,734	0.00	633	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	2,076	0.00	169	31.00	
41.00	04100	SUBPROVIDER - IRF	0		0	2,150	0.00	74	41.00	
43.00	04300	NURSERY			0	1,951	0.00	430	43.00	
200.00		Total (lines 30 through 199)			0	31,911		1,306	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	
41.00	04100	SUBPROVIDER - IRF		0					41.00	
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: 14-0046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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	03951	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	06901	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
76.00	03950	ENDOSCOPY		0	0	0	0	0	76.00
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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:16 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	59,564,585	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,892,125	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,525,683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,326,985	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,135,053	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,566,690	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,399,350	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,331,619	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,566,068	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,764,617	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	78,417,514	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,035,855	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,154,619	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,525,239	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	110,310	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,222,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,297,413	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,418,426	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	687,055	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	312,980	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,750,398	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,945,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,354,429	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,837,935	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	4,335,855	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,646,829	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,031,295	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,207,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	517,363,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0.000000	0	0	0	0	76.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:

Worksheet D

Component CCN: 14-T046

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/27/2020 2:16 pm

Title XIX				Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,274,713	59,564,585	0.038189	0	0 50.00
51.00	05100 RECOVERY ROOM	24,394	7,892,125	0.003091	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	650,360	13,525,683	0.048083	0	0 52.00
53.00	05300 ANESTHESIOLOGY	29,573	11,326,985	0.002611	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,284,858	22,135,053	0.058046	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	52,577	4,566,690	0.011513	0	0 55.00
56.00	05600 RADIOISOTOPE	18,002	10,399,350	0.001731	0	0 56.00
57.00	05700 CT SCAN	241,003	50,331,619	0.004788	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	198,916	9,566,068	0.020794	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	423,457	37,764,617	0.011213	0	0 59.00
60.00	06000 LABORATORY	631,137	78,417,514	0.008048	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	90,459	2,035,855	0.044433	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	181,747	17,154,619	0.010595	0	0 65.00
66.00	06600 PHYSICAL THERAPY	239,227	7,525,239	0.031790	0	0 66.00
66.01	03951 CLINICAL NUTRITION	8,909	110,310	0.080763	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	196,123	3,222,206	0.060866	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	46,147	1,297,413	0.035568	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	957,491	20,418,426	0.046893	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	12,548	687,055	0.018263	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	65,877	312,980	0.210483	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129,742	12,750,398	0.010176	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	76,486	16,945,113	0.004514	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	738,268	76,354,429	0.009669	0	0 73.00
74.00	07400 RENAL DIALYSIS	10,620	1,837,935	0.005778	0	0 74.00
76.00	03950 ENDOSCOPY	77,510	4,335,855	0.017877	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	889,140	11,646,829	0.076342	0	0 90.00
91.00	09100 EMERGENCY	930,373	33,031,295	0.028166	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,207,308	0.000000	0	0 92.00
200.00	Total (lines 50 through 199)	10,479,657	517,363,554		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	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	03951	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	06901	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
76.00	03950	ENDOSCOPY		0	0	0	0	0	76.00
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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	59,564,585	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,892,125	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,525,683	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,326,985	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,135,053	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,566,690	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	10,399,350	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,331,619	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,566,068	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,764,617	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	78,417,514	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,035,855	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,154,619	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,525,239	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	110,310	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,222,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,297,413	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,418,426	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	687,055	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	312,980	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,750,398	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,945,113	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,354,429	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,837,935	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	4,335,855	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,646,829	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,031,295	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,207,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	517,363,554		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	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	03951	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	06901	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
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
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: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			25,734	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			25,734	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)			23,711	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)			13,313	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)			33,274,604	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)			33,274,604	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)			33,274,604	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)			1,293.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			17,213,975	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)			17,213,975	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:16 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	5,941,079	2,076	2,861.79	1,220	3,491,384
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)					23,035,051
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					43,740,410
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,674,363
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,127,140
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,801,503
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					38,938,907
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)					2,023
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,293.02
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,615,779

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:16 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,978,419	33,274,604	0.119563	2,615,779	312,750	90.00
91.00	Nursing School cost	0	33,274,604	0.000000	2,615,779	0	91.00
92.00	Allied health cost	0	33,274,604	0.000000	2,615,779	0	92.00
93.00	All other Medical Education	0	33,274,604	0.000000	2,615,779	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				
			1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,150	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,150	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)	2,150	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)	1,613	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00	
15.00	Total nursery days (title V or XIX only)	0	15.00	
16.00	Nursery days (title V or XIX only)	0	16.00	
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)	3,283,583	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00	
26.00	Total swing-bed cost (see instructions)	0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,283,583	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00	
29.00	Private room charges (excluding swing-bed charges)	0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,283,583	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)	1,527.25	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,463,454	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,463,454	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,004,007	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,467,461	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)					420,638	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					86,114	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					506,752	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,960,709	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	560,685	3,283,583	0.170754	0	0	90.00
91.00	Nursing School cost	0	3,283,583	0.000000	0	0	91.00
92.00	Allied health cost	0	3,283,583	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,283,583	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
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Title XIX		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,734	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,734	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)	23,711	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)	633	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)	1,951	15.00
16.00	Nursery days (title V or XIX only)	430	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)	33,274,604	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)	33,274,604	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)	33,274,604	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)	1,293.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	818,482	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	818,482	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

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Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	1,502,226	1,951	769.98	430	331,091
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,941,079	2,076	2,861.79	169	483,643
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)					1,633,216
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					209,486
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)					209,486
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,423,730
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)					2,023
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,293.02
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,615,779

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
8/27/2020 2:16 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	3,978,419	33,274,604	0.119563	2,615,779	312,750
91.00	Nursing School cost	0	33,274,604	0.000000	2,615,779	0
92.00	Allied health cost	0	33,274,604	0.000000	2,615,779	0
93.00	All other Medical Education	0	33,274,604	0.000000	2,615,779	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,150	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)		2,150	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)		74	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)		1,951	15.00
16.00	Nursery days (title V or XIX only)		430	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,283,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,283,583	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,283,583	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)		1,527.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		113,017	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)		113,017	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm	
				Title XIX		Subprovider - IRF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					113,017	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)					19,298	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)					19,298	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					93,719	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/27/2020 2:16 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	560,685	3,283,583	0.170754	0	0	90.00
91.00	Nursing School cost	0	3,283,583	0.000000	0	0	91.00
92.00	Allied health cost	0	3,283,583	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,283,583	0.000000	0	0	93.00

Health Financial Systems		SSM HEALTH GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 2:16 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		18,314,660	30.00
31.00	03100	INTENSIVE CARE UNIT		2,770,580	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.170918	18,974,313	50.00
51.00	05100	RECOVERY ROOM	0.101036	1,909,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.432788	6,900	52.00
53.00	05300	ANESTHESIOLOGY	0.040983	2,652,365	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244726	2,815,095	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.394521	700	55.00
56.00	05600	RADIOISOTOPE	0.074011	1,221,740	56.00
57.00	05700	CT SCAN	0.029432	7,669,385	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.079844	798,925	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079099	7,429,800	59.00
60.00	06000	LABORATORY	0.108973	18,117,485	60.00
64.00	06400	INTRAVENOUS THERAPY	0.440654	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.164620	8,575,030	65.00
66.00	06600	PHYSICAL THERAPY	0.331000	2,370,951	66.00
66.01	03951	CLINICAL NUTRITION	3.793899	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.384700	703,506	67.00
68.00	06800	SPEECH PATHOLOGY	0.445055	182,790	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171455	6,052,220	69.00
69.01	06901	CARDIAC REHABILITATION	0.566645	20,945	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.630635	164,757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.742217	5,098,865	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319804	5,903,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287032	16,679,200	73.00
74.00	07400	RENAL DIALYSIS	0.374379	1,217,690	74.00
76.00	03950	ENDOSCOPY	0.083669	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.563374	1,475	90.00
91.00	09100	EMERGENCY	0.213258	4,505,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.185054	233,709	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		113,306,253	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)		113,306,253	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/27/2020 2:16 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		1,911,405		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.170918	10,265	1,754	50.00
51.00	05100 RECOVERY ROOM	0.101036	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.432788	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.040983	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244726	29,705	7,270	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.394521	0	0	55.00
56.00	05600 RADIOISOTOPE	0.074011	3,170	235	56.00
57.00	05700 CT SCAN	0.029432	35,785	1,053	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.079844	6,150	491	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.079099	0	0	59.00
60.00	06000 LABORATORY	0.108973	229,201	24,977	60.00
64.00	06400 INTRAVENOUS THERAPY	0.440654	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.164620	178,970	29,462	65.00
66.00	06600 PHYSICAL THERAPY	0.331000	1,863,010	616,656	66.00
66.01	03951 CLINICAL NUTRITION	3.793899	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.384700	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.445055	245,300	109,172	68.00
69.00	06900 ELECTROCARDIOLOGY	0.171455	14,195	2,434	69.00
69.01	06901 CARDIAC REHABILITATION	0.566645	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.630635	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.742217	73,150	54,293	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.319804	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287032	293,860	84,347	73.00
74.00	07400 RENAL DIALYSIS	0.374379	39,830	14,912	74.00
76.00	03950 ENDOSCOPY	0.083669	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.563374	65	37	90.00
91.00	09100 EMERGENCY	0.213258	266,880	56,914	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.185054	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,289,536	1,004,007	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)		3,289,536		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 2:16 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)			20,079,131	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			7,234,941	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)			586,098	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			94,959	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)			109.46	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)			4.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)			21.83	31.00
32.00	Sum of lines 30 and 31			26.49	32.00
33.00	Allowable disproportionate share percentage (see instructions)			11.07	33.00
34.00	Disproportionate share adjustment (see instructions)			755,917	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/27/2020 2:16 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)		0.000142692	0.000144602
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,180,475	1,207,516
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		882,930	303,528
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,186,458	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.0000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		29,937,504	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		29,937,504	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,341,373	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		32,278,877	
60.00	Primary payer payments		573	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		32,278,304	
62.00	Deductibles billed to program beneficiaries		2,983,736	
63.00	Coinurance billed to program beneficiaries		70,880	
64.00	Allowable bad debts (see instructions)		655,726	
65.00	Adjusted reimbursable bad debts (see instructions)		426,222	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		505,961	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		29,649,910	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		-137,750	
70.94	HRR adjustment amount (see instructions)		-371,749	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
8/27/2020 2:16 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	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		29,140,411	71.00	
71.01	Sequestration adjustment (see instructions)		582,808	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		28,491,534	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)		66,069	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		625,213	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 2:16 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	20,079,131	0	20,079,131		20,079,131
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,234,941	0		7,234,941	7,234,941
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	586,098	0	586,098		586,098
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	94,959	0		94,959	94,959
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	0.1107	0.1107	0.1107	0.1107	
11.00	Disproportionate share adjustment (see instructions)	34.00	755,917	0	555,690	200,227	755,917
11.01	Uncompensated care payments	36.00	1,186,458	0	882,930	303,528	1,186,458
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	29,937,504	0	22,103,849	7,833,655	29,937,504
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	29,937,504	0	22,103,849	7,833,655	29,937,504
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,341,373	0	1,738,716	602,657	2,341,373

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/27/2020 2:16 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	23,842,565	8,436,312	32,278,877
		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	2,196,104	0	1,622,337	573,767	2,196,104
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	145,269	0	116,379	28,890	145,269
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	2,341,373	0	1,738,716	602,657	2,341,373
		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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 2:16 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	20,079,131	20,079,131		20,079,131	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,234,941		7,234,941	7,234,941	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	586,098	586,098		586,098	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	94,959		94,959	94,959	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	0.1107	0.1107	0.1107		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	755,917	555,690	200,227	755,917	11.00
11.01	Uncompensated care payments	36.00	1,186,458	882,930	303,528	1,186,458	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	29,937,504	22,103,849	7,833,655	29,937,504	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	29,937,504	22,103,849	7,833,655	29,937,504	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,341,373	1,738,716	602,657	2,341,373	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			23,842,565	8,436,312	32,278,877	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/27/2020 2:16 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	2,196,104	1,622,337	573,767	2,196,104	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	145,269	116,379	28,890	145,269	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	2,341,373	1,738,716	602,657	2,341,373	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	-137,750	-104,132	-33,618	-137,750	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-371,749	-323,274	-48,475	-371,749	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/27/2020 2:16 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		33,387	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,118,666	2.00
3.00	OPPS payments		21,234,296	3.00
4.00	Outlier payment (see instructions)		90,243	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)		33,387	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		116,319	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)		116,319	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)		116,319	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		82,932	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)		33,387	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)		21,324,539	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)		3,903,436	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)		17,454,490	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)		17,454,490	30.00
31.00	Primary payer payments		732	31.00
32.00	Subtotal (line 30 minus line 31)		17,453,758	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)		571,747	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		371,636	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		396,596	36.00
37.00	Subtotal (see instructions)		17,825,394	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-66	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)		17,825,460	40.00
40.01	Sequestration adjustment (see instructions)		356,509	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		17,439,054	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)		29,897	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: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 2:16 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		27,978,745		17,101,136	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		512,789		337,918	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		28,491,534		17,439,054	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		66,069		29,897	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		28,557,603		17,468,951	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: 14-0046
 Component CCN: 14-T046

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/27/2020 2:16 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,970,245			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,970,245			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0			0	6.01
6.02	SETTLEMENT TO PROGRAM		6,064			0	6.02
7.00	Total Medicare program liability (see instructions)		2,964,181			0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/27/2020 2:16 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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 8/27/2020 2:16 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		2,700,016	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0413	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		83,430	3.00
4.00	Outlier Payments		254,816	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		5.890411	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		3,038,262	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		3,038,262	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		3,038,262	19.00
20.00	Deductibles		13,640	20.00
21.00	Subtotal (line 19 minus line 20)		3,024,622	21.00
22.00	Coinsurance		1,705	22.00
23.00	Subtotal (line 21 minus line 22)		3,022,917	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		2,704	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		1,758	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,704	26.00
27.00	Subtotal (sum of lines 23 and 25)		3,024,675	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		3,024,675	32.00
32.01	Sequestration adjustment (see instructions)		60,494	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		2,970,245	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-6,064	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		254,816	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: 14-0046

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

Worksheet G

Date/Time Prepared:
8/27/2020 2:16 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	36,409,497	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	22,769,575	0	0	0	4.00
5.00	Other receivable	2,370,446	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,323,383	0	0	0	7.00
8.00	Prepaid expenses	1,679,401	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)	67,552,302	0	0	0	11.00
FIXED ASSETS						
12.00	Land	590,251	0	0	0	12.00
13.00	Land improvements	6,818,606	0	0	0	13.00
14.00	Accumulated depreciation	-4,984,832	0	0	0	14.00
15.00	Buildings	172,761,421	0	0	0	15.00
16.00	Accumulated depreciation	-47,905,602	0	0	0	16.00
17.00	Leasehold improvements	19,324,569	0	0	0	17.00
18.00	Accumulated depreciation	-6,158,696	0	0	0	18.00
19.00	Fixed equipment	17,399,549	0	0	0	19.00
20.00	Accumulated depreciation	-8,072,990	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	51,520,384	0	0	0	23.00
24.00	Accumulated depreciation	-39,301,790	0	0	0	24.00
25.00	Minor equipment depreciable	414,219	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)	162,405,089	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,913,851	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	40,598,337	555,206	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	44,512,188	555,206	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	274,469,579	555,206	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,555,527	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,190,040	0	0	0	38.00
39.00	Payroll taxes payable	121,652	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,003,916	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	732,875	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,604,010	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	165,126,908	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-249,767	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	164,877,141	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	181,481,151	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	92,988,428				52.00
53.00	Specific purpose fund		555,206			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)	92,988,428	555,206	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	274,469,579	555,206	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

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

Worksheet G-1

Date/Time Prepared:
8/27/2020 2:16 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		96,480,277		414,435		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,069,583				2.00
3.00	Total (sum of line 1 and line 2)		109,549,860		414,435		3.00
4.00	Additions	0		140,771		0	4.00
5.00	CORPORATE OFFICE	622,330		0		0	5.00
6.00		0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA	185,826		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)		808,156		140,771		10.00
11.00	Subtotal (line 3 plus line 10)		110,358,016		555,206		11.00
12.00	Deductions	17,369,588		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		17,369,588		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		92,988,428		555,206		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	CORPORATE OFFICE		0				5.00
6.00			0				6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA		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			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 2:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	36,973,395		36,973,395	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,705,390		2,705,390	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)	39,678,785		39,678,785	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,750,685		5,750,685	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)	5,750,685		5,750,685	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,429,470		45,429,470	17.00
18.00	Ancillary services	210,211,685	260,266,435	470,478,120	18.00
19.00	Outpatient services	8,124,144	38,761,288	46,885,432	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON REIMBURSABLE	0	-46,656	-46,656	27.00
27.01	ORGAN ACQUISITION	0	0	0	27.01
27.02	PROFESSIONAL FEES	14,289,283	8,128,008	22,417,291	27.02
27.03	EMPLOYEE HEALTH INSURANCE	3,709,420	8,168,038	11,877,458	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	281,764,002	315,277,113	597,041,115	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		179,917,614		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)		179,917,614		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0046

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

Worksheet G-3

Date/Time Prepared:
8/27/2020 2:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	597,041,115	1.00
2.00	Less contractual allowances and discounts on patients' accounts	416,285,282	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,755,833	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	179,917,614	4.00
5.00	Net income from service to patients (line 3 minus line 4)	838,219	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,646,368	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	693,610	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	8,579	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	40,854	21.00
22.00	Rental of hospital space	355,310	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	7,486,643	24.00
25.00	Total other income (sum of lines 6-24)	12,231,364	25.00
26.00	Total (line 5 plus line 25)	13,069,583	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,069,583	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/27/2020 2:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,196,104	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		145,269	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)		72.91	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)		2,341,373	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