

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: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 11:28 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/28/2020	Time: 11:28 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TOUCHETTE REGIONAL HOSPITAL (14-0077) 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) THOMAS CHAUNDY

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-26,954	-77,487	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-26,954	-77,487	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: 14-0077		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 11:28 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5900 BOND STREET			PO Box:				1.00		
2.00	City: CENTREVILLE			State: IL		Zip Code: 62207		County: ST. CLAIR 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		TOUCHETTE REGIONAL HOSPITAL	140077	41180	1	07/01/1966	N	P N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA		SOUTHERN ILLINOIS HOME CARE	147315	41180		01/01/1996	N	P N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2019		12/31/2019		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				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.		731	1,159	167	74	2,766	5		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0077		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 11:28 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/28/2020 11:28 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/28/2020 11:28 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 11:28 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,367,770	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0077		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 11:28 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 2041 GOOSE LAKE ROAD	PO Box:						142.00	
143.00	City: SAUGET	State:		Zip Code: 62206				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 11:28 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/26/2020	Y
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)	N		N
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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/28/2020 11:28 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 11:28 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	123	44,895	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)		123	44,895	0.00	0	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	43.00				0	13.00
14.00 Total (see instructions)		123	44,895	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		123			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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 11:28 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,579	724	8,495			1.00
2.00	HMO and other (see instructions)	0	4,170				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,579	724	8,495			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		3	67			13.00
14.00	Total (see instructions)	1,579	727	8,562	0.00	389.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	1,210	0.00	5.39	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	394.65	27.00
28.00	Observation Bed Days		0	812			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	5	7			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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 11:28 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	391	1,274	2,285	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	391	1,274	2,285	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 11:28 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	23,595,672	0	23,595,672	820,862.75	28.74
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		362,178	0	362,178	4,215.46	85.92
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)		2,153,970	0	2,153,970	54,380.52	39.61
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,749,441	0	2,749,441	40,856.56	67.29
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		30,500	0	30,500	230.00	132.61
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		0	0	0	0.00	0.00
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)		5,421,073	0	5,421,073		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		437,054	0	437,054		
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		43,303	0	43,303		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 11:28 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	425,161	0	425,161	11,218.68	37.90	26.00
27.00	Administrative & General	5.00	4,622,097	0	4,622,097	153,638.88	30.08	27.00
28.00	Administrative & General under contract (see inst.)		265,508	0	265,508	797.25	333.03	28.00
29.00	Maintenance & Repairs	6.00	601,781	0	601,781	23,571.78	25.53	29.00
30.00	Operation of Plant	7.00	1,170,381	0	1,170,381	62,656.23	18.68	30.00
31.00	Laundry & Linen Service	8.00	24,955	0	24,955	2,164.98	11.53	31.00
32.00	Housekeeping	9.00	544,740	0	544,740	44,818.02	12.15	32.00
33.00	Housekeeping under contract (see instructions)		66,029	0	66,029	2,080.00	31.74	33.00
34.00	Dietary	10.00	429,750	-331,712	98,038	7,058.45	13.89	34.00
35.00	Dietary under contract (see instructions)		197,574	0	197,574	6,348.00	31.12	35.00
36.00	Cafeteria	11.00	0	331,712	331,712	23,882.35	13.89	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	506,279	0	506,279	12,458.89	40.64	38.00
39.00	Central Services and Supply	14.00	97,630	0	97,630	6,000.71	16.27	39.00
40.00	Pharmacy	15.00	710,506	-710,506	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	616,804	0	616,804	29,596.98	20.84	41.00
42.00	Social Service	17.00	159,816	0	159,816	5,789.38	27.61	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/28/2020 11:28 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	23,762,605	0	23,762,605	825,872.54	28.77	1.00
2.00	Excluded area salaries (see instructions)	2,153,970	0	2,153,970	54,380.52	39.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	21,608,635	0	21,608,635	771,492.02	28.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,779,941	0	2,779,941	41,086.56	67.66	4.00
5.00	Subtotal wage-related costs (see inst.)	5,421,073	0	5,421,073	0.00	25.09	5.00
6.00	Total (sum of lines 3 thru 5)	29,809,649	0	29,809,649	812,578.58	36.69	6.00
7.00	Total overhead cost (see instructions)	10,439,011	-710,506	9,728,505	392,080.58	24.81	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/28/2020 11:28 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	597,699	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)	0	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)	2,852,876	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,161	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)	111,085	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	306,629	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	1,740,270	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	188,053	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	47,657	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,901,430	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: 14-0077

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 8/28/2020 11:28 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,778,955	5,901,430	1.00
2.00	Hospital	2,749,441	5,800,159	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	29,514	101,271	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		TOUCHETTE REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10	
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0077 Component CCN: 14-7315		Period: From 01/01/2019 To 12/31/2019	Worksheet S-4 Date/Time Prepared: 8/28/2020 11:28 am	
				Home Health Agency I	PPS	
				1.00		
0.00	County	ST. CLAIR				0.00
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00
HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	43.00	68.00	2.00
		Number of Employees (Full Time Equivalent)				
		Enter the number of hours in your normal work week		Staff	Contract	Total
		0		1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	4.00
5.00	Other Administrative Personnel			0.99	0.00	5.00
6.00	Direct Nursing Service			1.83	0.00	6.00
7.00	Nursing Supervisor			1.99	0.00	7.00
8.00	Physical Therapy Service			0.55	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	9.00
10.00	Occupational Therapy Service			0.02	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	41180				20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	0	0	0	0	21.00
22.00	Skilled Nursing Visit Charges	0	0	0	0	22.00
23.00	Physical Therapy Visits	0	0	0	0	23.00
24.00	Physical Therapy Visit Charges	0	0	0	0	24.00
25.00	Occupational Therapy Visits	0	0	0	0	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	26.00
27.00	Speech Pathology Visits	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	0	0	0	0	33.00
34.00	Other Charges	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0	0	0	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/28/2020 11:28 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.807283	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			9,842,504	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			27,783,687	5.00
6.00	Medicaid charges			34,532,109	6.00
7.00	Medicaid cost (line 1 times line 6)			27,877,185	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)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			14,631	9.00
10.00	Stand-alone CHIP charges			103,184	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			83,299	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			68,668	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)			68,668	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,514,849	74,016	3,588,865	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,837,478	74,016	2,911,494	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,794	0	1,794	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,835,684	74,016	2,909,700	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,038,975	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			165,353	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			254,390	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,784,585	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,529,702	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,439,402	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,508,070	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

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

Worksheet A

Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,266,559	1,266,559	156,979	1,423,538
2.00	00200	CAP REL COSTS-MVBLE EQUIP		515,761	515,761	77,336	593,097
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	425,161	4,456,728	4,881,889	-51,209	4,830,680
5.00	00500	ADMINISTRATIVE & GENERAL	4,622,097	7,855,979	12,478,076	263,788	12,741,864
6.00	00600	MAINTENANCE & REPAIRS	601,781	445,450	1,047,231	0	1,047,231
7.00	00700	OPERATION OF PLANT	1,170,381	843,614	2,013,995	0	2,013,995
8.00	00800	LAUNDRY & LINEN SERVICE	24,955	89,976	114,931	0	114,931
9.00	00900	HOUSEKEEPING	544,740	317,660	862,400	0	862,400
10.00	01000	DIETARY	429,750	588,929	1,018,679	-786,290	232,389
11.00	01100	CAFETERIA	0	0	0	786,290	786,290
13.00	01300	NURSING ADMINISTRATION	506,279	50,577	556,856	0	556,856
14.00	01400	CENTRAL SERVICES & SUPPLY	97,630	11,518	109,148	0	109,148
15.00	01500	PHARMACY	710,506	339,904	1,050,410	-710,506	339,904
16.00	01600	MEDICAL RECORDS & LIBRARY	616,804	150,690	767,494	0	767,494
17.00	01700	SOCIAL SERVICE	159,816	15,420	175,236	0	175,236
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,528,912	2,203,206	6,732,118	968,158	7,700,276
43.00	04300	NURSERY	228,857	23,837	252,694	0	252,694
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	877,466	661,412	1,538,878	0	1,538,878
52.00	05200	DELIVERY ROOM & LABOR ROOM	577,770	1,061,847	1,639,617	-946,789	692,828
53.00	05300	ANESTHESIOLOGY	0	912,455	912,455	0	912,455
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,296,852	658,443	1,955,295	0	1,955,295
60.00	06000	LABORATORY	625,223	2,115,533	2,740,756	0	2,740,756
65.00	06500	RESPIRATORY THERAPY	584,734	323,916	908,650	0	908,650
66.00	06600	PHYSICAL THERAPY	0	454,722	454,722	0	454,722
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,783	140,783	0	140,783
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,608	115,608	0	115,608
73.00	07300	DRUGS CHARGED TO PATIENTS	0	351,195	351,195	710,506	1,061,701
74.00	07400	RENAL DIALYSIS	0	41,463	41,463	0	41,463
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	567,849	417,296	985,145	0	985,145
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,244,139	3,643,474	5,887,613	0	5,887,613
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	404,913	110,552	515,465	0	515,465
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		498,103	498,103	-498,103	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,846,615	30,682,610	52,529,225	-29,840	52,499,385
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,350,353	2,721,812	4,072,165	29,840	4,102,005
194.00	07950	OTHER NONREIMBURSABLE - GRANT	146,351	34,383	180,734	0	180,734
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	252,353	-99,624	152,729	0	152,729
200.00		TOTAL (SUM OF LINES 118 through 199)	23,595,672	33,339,181	56,934,853	0	56,934,853

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet A
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-610	1,422,928	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,099	587,998	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,830,680	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,294,028	10,447,836	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,047,231	6.00
7.00	00700	OPERATION OF PLANT	0	2,013,995	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,931	8.00
9.00	00900	HOUSEKEEPING	0	862,400	9.00
10.00	01000	DIETARY	0	232,389	10.00
11.00	01100	CAFETERIA	-255,623	530,667	11.00
13.00	01300	NURSING ADMINISTRATION	-612	556,244	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	109,148	14.00
15.00	01500	PHARMACY	0	339,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-37,439	730,055	16.00
17.00	01700	SOCIAL SERVICE	-130	175,106	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-985,689	6,714,587	30.00
43.00	04300	NURSERY	0	252,694	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,538,878	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-235,000	457,828	52.00
53.00	05300	ANESTHESIOLOGY	-900,312	12,143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,955,295	54.00
60.00	06000	LABORATORY	0	2,740,756	60.00
65.00	06500	RESPIRATORY THERAPY	-64,196	844,454	65.00
66.00	06600	PHYSICAL THERAPY	-100	454,622	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,061,701	73.00
74.00	07400	RENAL DIALYSIS	0	41,463	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-127,894	857,251	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-3,301,903	2,585,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	515,465	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,208,635	44,290,750	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,102,005	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	180,734	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	152,729	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,208,635	48,726,218	200.00

RECLASSIFICATIONS

Provider CCN: 14-0077

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

Worksheet A-6

Date/Time Prepared:
8/28/2020 11:28 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CAFETERIA COSTS					1.00
	CAFETERIA	11.00	331,712	454,578		
	0		331,712	454,578		
1.00	B - ER & HOSPITALIST PHYSICIAN BENEFITS					1.00
	ADULTS & PEDIATRICS	30.00	0	21,369		
	0		0	21,369		
1.00	C - CLINIC PHYSICIAN BENEFITS					1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	0	29,840		
	0		0	29,840		
1.00	D - INTEREST EXPENSE					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,504		
	ADMINISTRATIVE & GENERAL	5.00	0	440,033		
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,566	3.00	
	0		0	498,103		
	E - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	176,245	1.00	
	0	0.00	0	0		
	0		0	176,245		
1.00	F - LABOR & DELIVERY					1.00
	ADULTS & PEDIATRICS	30.00	389,449	557,340		
	0		389,449	557,340		
1.00	G - PHARMACY SALARIES					1.00
	DRUGS CHARGED TO PATIENTS	73.00	710,506	0		
	0		710,506	0		
500.00	Grand Total: Increases		1,431,667	1,737,475	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0077

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

Worksheet A-6

Date/Time Prepared:
8/28/2020 11:28 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA COSTS						
1.00	DIETARY	10.00	331,712	454,578	0	1.00
	0		331,712	454,578		
B - ER & HOSPITALIST PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21,369	0	1.00
	0		0	21,369		
C - CLINIC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29,840	0	1.00
	0		0	29,840		
D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	498,103	11	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	11	3.00
	0		0	498,103		
E - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	176,245	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	176,245		
F - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	389,449	557,340	0	1.00
	0		389,449	557,340		
G - PHARMACY SALARIES						
1.00	PHARMACY	15.00	710,506	0	0	1.00
	0		710,506	0		
500.00	Grand Total: Decreases		1,431,667	1,737,475		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/28/2020 11:28 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,222,647	0	0	0	0	1.00	
2.00	Land Improvements	307,583	0	0	0	0	2.00	
3.00	Buildings and Fixtures	29,451,351	1,226,296	0	1,226,296	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	706,910	81,269	0	81,269	0	5.00	
6.00	Movable Equipment	13,230,424	548,687	0	548,687	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	45,918,915	1,856,252	0	1,856,252	0	8.00	
9.00	Reconciling Items	-1,172,894	-606,411	0	-606,411	-1,292,740	9.00	
10.00	Total (line 8 minus line 9)	47,091,809	2,462,663	0	2,462,663	1,292,740	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,222,647	0					1.00
2.00	Land Improvements	307,583	0					
3.00	Buildings and Fixtures	30,677,647	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	788,179	0					
6.00	Movable Equipment	13,779,111	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	47,775,167	0					
9.00	Reconciling Items	-486,565	0					
10.00	Total (line 8 minus line 9)	48,261,732	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,266,559	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	515,761	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,782,320	0	0	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	1,266,559				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	515,761				2.00
3.00	Total (sum of lines 1-2)	0	1,782,320				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	33,996,056	0	33,996,056	0.711584	125,413	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,779,111	0	13,779,111	0.288416	50,832	2.00
3.00	Total (sum of lines 1-2)	47,775,167	0	47,775,167	1.000000	176,245	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	125,413	1,266,559	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	50,832	511,174	0	2.00
3.00	Total (sum of lines 1-2)	0	0	176,245	1,777,733	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,956	125,413	0	0	1,422,928	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,992	50,832	0	0	587,998	2.00
3.00	Total (sum of lines 1-2)	56,948	176,245	0	0	2,010,926	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-610	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-512	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-8,501	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-466	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-4,655	ADMINISTRATIVE & GENERAL	5.00	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)	A	-28,346	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,571,559			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	-86,652			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-255,623	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-448	NURSING ADMINISTRATION	13.00	0	17.00
18.00	Sale of medical records and abstracts	B	-37,439	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-113,518	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	POST PT FIT	B	-100	PHYSICAL THERAPY	66.00	0	33.01
33.02	OTHER INCOME	B	-42,558	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.02
34.00	LOBBYING COSTS	A	-14,514	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MARKETING COSTS - OTHER EXPENSES	A	-71,612	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	NON-ALLOWABLE ADVERTISING	A	-782	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON-ALLOWABLE ADVERTISING	A	-130	SOCIAL SERVICE	17.00	0	35.02
36.00	NON-ALLOWABLE ADVERTISING	A	-877	ADULTS & PEDIATRICS	30.00	0	36.00
37.00	NON-ALLOWABLE ADVERTISING	A	-164	NURSING ADMINISTRATION	13.00	0	37.00
38.00	PROVIDER TAX	A	-1,964,982	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	AMORTIZE EQUIPMENT INSURANCE PROCEED	A	-4,587	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,208,635				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: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 11:28 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	SIHF SERVICES	0	86,652	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	86,652	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 11:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-86,652	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-86,652			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	NOT FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0077

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

Worksheet A-8-2

Date/Time Prepared:
8/28/2020 11:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	997,536	979,036	18,500	197,500	134	1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	235,000	235,000	0	237,100	0	2.00
3.00	53.00	ANESTHESIOLOGY	900,312	900,312	0	239,400	0	3.00
4.00	65.00	RESPIRATORY THERAPY	64,196	64,196	0	211,500	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,704	81,704	12,000	181,300	96	5.00
6.00	91.00	EMERGENCY	3,301,903	3,301,903	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,592,651	5,562,151	30,500		230	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	12,724	636	0	0	0	1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,368	418	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			21,092	1,054	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	12,724	5,776	984,812		1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	235,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	900,312		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	64,196		4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8,368	3,632	85,336		5.00
6.00	91.00	EMERGENCY	0	0	0	3,301,903		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	21,092	9,408	5,571,559		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,422,928	1,422,928			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	587,998		587,998		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,830,680	9,118	3,768	4,843,566	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,447,836	80,729	33,360	1,027,590	11,589,515
6.00	00600	MAINTENANCE & REPAIRS	1,047,231	68,589	28,343	133,789	1,277,952
7.00	00700	OPERATION OF PLANT	2,013,995	214,483	88,631	260,201	2,577,310
8.00	00800	LAUNDRY & LINEN SERVICE	114,931	10,937	4,520	5,548	135,936
9.00	00900	HOUSEKEEPING	862,400	21,239	8,777	121,108	1,013,524
10.00	01000	DIETARY	232,389	60,547	25,020	21,796	339,752
11.00	01100	CAFETERIA	530,667	21,943	9,068	73,747	635,425
13.00	01300	NURSING ADMINISTRATION	556,244	34,691	14,335	112,557	717,827
14.00	01400	CENTRAL SERVICES & SUPPLY	109,148	18,001	7,438	21,705	156,292
15.00	01500	PHARMACY	339,904	15,076	6,230	0	361,210
16.00	01600	MEDICAL RECORDS & LIBRARY	730,055	26,228	10,838	137,129	904,250
17.00	01700	SOCIAL SERVICE	175,106	4,647	1,920	35,531	217,204
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,714,587	383,141	158,325	1,012,940	8,268,993
43.00	04300	NURSERY	252,694	14,117	5,834	50,880	323,525
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,538,878	127,893	52,849	195,080	1,914,700
52.00	05200	DELIVERY ROOM & LABOR ROOM	457,828	8,580	3,545	41,868	511,821
53.00	05300	ANESTHESIOLOGY	12,143	0	0	0	12,143
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,955,295	37,185	15,366	288,319	2,296,165
60.00	06000	LABORATORY	2,740,756	38,222	15,795	139,001	2,933,774
65.00	06500	RESPIRATORY THERAPY	844,454	35,170	14,533	129,999	1,024,156
66.00	06600	PHYSICAL THERAPY	454,622	30,288	12,516	0	497,426
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,783	0	0	0	140,783
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,608	0	0	0	115,608
73.00	07300	DRUGS CHARGED TO PATIENTS	1,061,701	0	0	157,961	1,219,662
74.00	07400	RENAL DIALYSIS	41,463	0	0	0	41,463
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	857,251	49,766	20,565	126,245	1,053,827
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,585,710	107,261	44,324	498,921	3,236,216
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	515,465	0	0	90,021	605,486
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,290,750	1,417,851	585,900	4,681,936	44,121,945
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,102,005	0	0	72,989	4,174,994
194.00	07950	OTHER NONREIMBURSABLE - GRANT	180,734	0	0	32,537	213,271
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	152,729	5,077	2,098	56,104	216,008
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	48,726,218	1,422,928	587,998	4,843,566	48,726,218

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,589,515				5.00
6.00	00600	MAINTENANCE & REPAIRS	398,819	1,676,771			6.00
7.00	00700	OPERATION OF PLANT	804,319	284,413	3,666,042		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,422	14,503	38,187	231,048	8.00
9.00	00900	HOUSEKEEPING	316,298	28,164	74,154	0	9.00
10.00	01000	DIETARY	106,029	80,288	211,396	0	10.00
11.00	01100	CAFETERIA	198,302	29,098	76,614	0	11.00
13.00	01300	NURSING ADMINISTRATION	224,017	46,001	121,120	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,775	23,870	62,848	0	14.00
15.00	01500	PHARMACY	112,725	19,991	52,636	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,196	34,780	91,574	0	16.00
17.00	01700	SOCIAL SERVICE	67,784	6,162	16,224	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,580,566	508,062	1,337,717	113,265	30.00
43.00	04300	NURSERY	100,965	18,720	49,288	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	597,534	169,592	446,531	6,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	159,728	11,377	29,955	2,259	52.00
53.00	05300	ANESTHESIOLOGY	3,790	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,580	49,309	129,830	34,658	54.00
60.00	06000	LABORATORY	915,563	50,684	133,450	0	60.00
65.00	06500	RESPIRATORY THERAPY	319,616	46,637	122,793	2,310	65.00
66.00	06600	PHYSICAL THERAPY	155,235	40,163	105,749	11,552	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,935	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,079	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,628	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	12,940	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	328,875	65,992	173,755	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,009,949	142,232	374,494	60,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	188,958	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,152,627	1,670,038	3,648,315	231,048	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,302,920	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	66,557	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	67,411	6,733	17,727	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,589,515	1,676,771	3,666,042	231,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	743,004					10.00
11.00	01100	CAFETERIA	0	958,826				11.00
13.00	01300	NURSING ADMINISTRATION	0	24,857	1,150,439			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,965	36,184	356,551		14.00
15.00	01500	PHARMACY	0	34,446	0	359	589,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,050	0	100	0	16.00
17.00	01700	SOCIAL SERVICE	0	11,544	0	5	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	743,004	314,262	357,363	46,078	6,890	30.00
43.00	04300	NURSERY	0	11,476	34,665	2,183	38	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	50,995	147,384	54,972	7,027	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,915	26,965	6,368	557	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,155	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,722	0	12,221	21,481	54.00
60.00	06000	LABORATORY	0	55,629	0	2,145	1,037	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,985	0	12,403	322	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,596	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	76,537	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	62,850	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	510,104	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	247	437	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	40,075	94,021	189	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	127,791	386,246	64,693	20,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	67,611	1,149	101	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	743,004	872,712	1,150,439	350,250	568,464	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,974	0	6,074	21,212	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	16,599	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	35,541	0	227	0	194.01
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)	743,004	958,826	1,150,439	356,551	589,676	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,385,798					16.00
17.00	01700	SOCIAL SERVICE	0	327,232				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,204,268	111,729	16,160,842	0	16,160,842	30.00
43.00	04300	NURSERY	4,823	10,838	570,369	0	570,369	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	46,080	3,621,637	0	3,621,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,431	784,399	0	784,399	52.00
53.00	05300	ANESTHESIOLOGY	0	0	22,088	0	22,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,399,083	0	3,399,083	54.00
60.00	06000	LABORATORY	0	0	4,133,782	0	4,133,782	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,610,722	0	1,610,722	65.00
66.00	06600	PHYSICAL THERAPY	0	0	858,760	0	858,760	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	261,255	0	261,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	214,537	0	214,537	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,110,394	0	2,110,394	73.00
74.00	07400	RENAL DIALYSIS	0	0	55,087	0	55,087	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,396	1,841,478	0	1,841,478	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	176,707	120,758	5,996,368	0	5,996,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	868,844	0	868,844	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,385,798	327,232	42,509,645	0	42,509,645	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,572,366	0	5,572,366	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	296,427	0	296,427	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	347,780	0	347,780	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,385,798	327,232	48,726,218	0	48,726,218	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
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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	9,118	3,768	12,886	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,652	80,729	33,360	235,741	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,455	68,589	28,343	98,387	6.00
7.00	00700	OPERATION OF PLANT	3,130	214,483	88,631	306,244	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,937	4,520	15,457	8.00
9.00	00900	HOUSEKEEPING	0	21,239	8,777	30,016	9.00
10.00	01000	DIETARY	0	60,547	25,020	85,567	10.00
11.00	01100	CAFETERIA	0	21,943	9,068	31,011	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,691	14,335	49,026	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	445	18,001	7,438	25,884	14.00
15.00	01500	PHARMACY	38,112	15,076	6,230	59,418	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,228	10,838	37,066	16.00
17.00	01700	SOCIAL SERVICE	0	4,647	1,920	6,567	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,744	383,141	158,325	544,210	30.00
43.00	04300	NURSERY	0	14,117	5,834	19,951	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	93,929	127,893	52,849	274,671	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,580	3,545	12,125	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,394	37,185	15,366	236,945	54.00
60.00	06000	LABORATORY	0	38,222	15,795	54,017	60.00
65.00	06500	RESPIRATORY THERAPY	11,929	35,170	14,533	61,632	65.00
66.00	06600	PHYSICAL THERAPY	0	30,288	12,516	42,804	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,679	49,766	20,565	81,010	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	107,261	44,324	151,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	468,469	1,417,851	585,900	2,472,220	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	170,076	0	0	170,076	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	21,672	0	0	21,672	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	5,077	2,098	7,175	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	660,217	1,422,928	587,998	2,671,143	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	238,482					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,207	106,950				6.00
7.00	00700	OPERATION OF PLANT	16,551	18,141	341,628			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	873	925	3,559	20,829		8.00
9.00	00900	HOUSEKEEPING	6,509	1,796	6,910	0	45,553	9.00
10.00	01000	DIETARY	2,182	5,121	19,699	0	176	10.00
11.00	01100	CAFETERIA	4,081	1,856	7,139	0	617	11.00
13.00	01300	NURSING ADMINISTRATION	4,610	2,934	11,287	0	529	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,004	1,522	5,857	0	529	14.00
15.00	01500	PHARMACY	2,320	1,275	4,905	0	264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,807	2,218	8,534	0	440	16.00
17.00	01700	SOCIAL SERVICE	1,395	393	1,512	0	264	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,093	32,407	124,658	10,211	18,089	30.00
43.00	04300	NURSERY	2,078	1,194	4,593	0	440	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,296	10,817	41,611	625	5,722	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,287	726	2,791	204	573	52.00
53.00	05300	ANESTHESIOLOGY	78	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,746	3,145	12,098	3,124	1,849	54.00
60.00	06000	LABORATORY	18,841	3,233	12,436	0	1,320	60.00
65.00	06500	RESPIRATORY THERAPY	6,577	2,975	11,443	208	1,320	65.00
66.00	06600	PHYSICAL THERAPY	3,194	2,562	9,854	1,041	1,496	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	904	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	742	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,833	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	266	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,768	4,209	16,192	0	1,760	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	20,783	9,072	34,898	5,416	8,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,888	0	0	0	176	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	208,913	106,521	339,976	20,829	44,366	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,812	0	0	0	1,056	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	1,370	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,387	429	1,652	0	131	194.01
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)	238,482	106,950	341,628	20,829	45,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	112,803					10.00
11.00	01100	CAFETERIA	0	44,900				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,164	69,849			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	560	2,197	37,611		14.00
15.00	01500	PHARMACY	0	1,613	0	38	69,833	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,765	0	11	0	16.00
17.00	01700	SOCIAL SERVICE	0	541	0	1	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	112,803	14,718	21,697	4,861	816	30.00
43.00	04300	NURSERY	0	537	2,105	230	4	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,388	8,948	5,799	832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	417	1,637	672	66	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,780	0	1,289	2,544	54.00
60.00	06000	LABORATORY	0	2,605	0	226	123	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,919	0	1,308	38	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	168	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,073	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,630	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	60,410	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	26	52	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,877	5,709	20	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,984	23,451	6,824	2,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	4,105	121	12	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,803	40,868	69,849	36,946	67,321	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,591	0	641	2,512	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	777	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	1,664	0	24	0	194.01
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)	112,803	44,900	69,849	37,611	69,833	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,206					16.00
17.00	01700	SOCIAL SERVICE	0	10,767				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,712	3,676	993,644	0	993,644	30.00
43.00	04300	NURSERY	199	357	31,823	0	31,823	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,516	365,744	0	365,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	277	22,886	0	22,886	52.00
53.00	05300	ANESTHESIOLOGY	0	0	727	0	727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	280,286	0	280,286	54.00
60.00	06000	LABORATORY	0	0	93,171	0	93,171	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	87,766	0	87,766	65.00
66.00	06600	PHYSICAL THERAPY	0	0	61,119	0	61,119	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8,977	0	8,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,372	0	7,372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	68,663	0	68,663	73.00
74.00	07400	RENAL DIALYSIS	0	0	344	0	344	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	967	118,848	0	118,848	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,295	3,974	281,834	0	281,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	8,541	0	8,541	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,206	10,767	2,431,745	0	2,431,745	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	202,882	0	202,882	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	23,905	0	23,905	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	12,611	0	12,611	194.01
200.00		Cross Foot Adjustments			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)	57,206	10,767	2,671,143	0	2,671,143	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0077

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

Worksheet B-1

Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	145,449					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		145,449				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	932	932	21,786,283			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,252	8,252	4,622,097	-11,589,515	37,136,703	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,011	7,011	601,781	0	1,277,952	6.00
7.00	00700	OPERATION OF PLANT	21,924	21,924	1,170,381	0	2,577,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,118	1,118	24,955	0	135,936	8.00
9.00	00900	HOUSEKEEPING	2,171	2,171	544,740	0	1,013,524	9.00
10.00	01000	DIETARY	6,189	6,189	98,038	0	339,752	10.00
11.00	01100	CAFETERIA	2,243	2,243	331,712	0	635,425	11.00
13.00	01300	NURSING ADMINISTRATION	3,546	3,546	506,279	0	717,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,840	1,840	97,630	0	156,292	14.00
15.00	01500	PHARMACY	1,541	1,541	0	0	361,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,681	2,681	616,804	0	904,250	16.00
17.00	01700	SOCIAL SERVICE	475	475	159,816	0	217,204	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,164	39,164	4,556,183	0	8,268,993	30.00
43.00	04300	NURSERY	1,443	1,443	228,857	0	323,525	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,073	13,073	877,466	0	1,914,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	877	877	188,321	0	511,821	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	12,143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,801	3,801	1,296,852	0	2,296,165	54.00
60.00	06000	LABORATORY	3,907	3,907	625,223	0	2,933,774	60.00
65.00	06500	RESPIRATORY THERAPY	3,595	3,595	584,734	0	1,024,156	65.00
66.00	06600	PHYSICAL THERAPY	3,096	3,096	0	0	497,426	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	140,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	115,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	710,506	0	1,219,662	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	41,463	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,087	5,087	567,849	0	1,053,827	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,964	10,964	2,244,139	0	3,236,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	404,913	0	605,486	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,930	144,930	21,059,276	-11,589,515	32,532,430	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	328,303	0	4,174,994	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	146,351	0	213,271	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	519	519	252,353	0	216,008	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,422,928	587,998	4,843,566		11,589,515	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.783003	4.042640	0.222322		0.312077	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,886		238,482	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000591		0.006422	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: 14-0077

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

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Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	129,254				6.00
7.00	00700	OPERATION OF PLANT	21,924	107,330			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,118	1,118	164,245		8.00
9.00	00900	HOUSEKEEPING	2,171	2,171	0	33,612	9.00
10.00	01000	DIETARY	6,189	6,189	0	130	29,402 10.00
11.00	01100	CAFETERIA	2,243	2,243	0	455	0 11.00
13.00	01300	NURSING ADMINISTRATION	3,546	3,546	0	390	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,840	1,840	0	390	0 14.00
15.00	01500	PHARMACY	1,541	1,541	0	195	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,681	2,681	0	325	0 16.00
17.00	01700	SOCIAL SERVICE	475	475	0	195	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,164	39,164	80,517	13,346	29,402 30.00
43.00	04300	NURSERY	1,443	1,443	0	325	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,073	13,073	4,927	4,222	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	877	877	1,606	423	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,801	3,801	24,637	1,364	0 54.00
60.00	06000	LABORATORY	3,907	3,907	0	974	0 60.00
65.00	06500	RESPIRATORY THERAPY	3,595	3,595	1,642	974	0 65.00
66.00	06600	PHYSICAL THERAPY	3,096	3,096	8,212	1,104	0 66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,087	5,087	0	1,299	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	10,964	10,964	42,704	6,495	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	130	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,735	106,811	164,245	32,736	29,402 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	779	0 192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	519	519	0	97	0 194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,676,771	3,666,042	231,048	1,432,140	743,004 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.972682	34.156732	1.406728	42.607997	25.270526 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	106,950	341,628	20,829	45,553	112,803 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.827441	3.182968	0.126817	1.355260	3.836576 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: 14-0077

Period:
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Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	56,896					11.00
13.00	01300	NURSING ADMINISTRATION	1,475	190,795				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	710	6,001	655,850			14.00
15.00	01500	PHARMACY	2,044	0	661	439,497		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,504	0	184	0	29,597	16.00
17.00	01700	SOCIAL SERVICE	685	0	9	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,648	59,267	84,758	5,135	25,720	30.00
43.00	04300	NURSERY	681	5,749	4,016	28	103	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,026	24,443	101,118	5,237	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	529	4,472	11,713	415	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	11,322	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,790	0	22,480	16,010	0	54.00
60.00	06000	LABORATORY	3,301	0	3,945	773	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,432	0	22,814	240	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,935	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	140,783	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	115,608	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	380,191	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	454	326	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,378	15,593	347	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,583	64,057	118,999	15,257	3,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	11,213	2,113	75	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,786	190,795	644,259	423,687	29,597	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,016	0	11,173	15,810	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	985	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	2,109	0	418	0	0	194.01
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)	958,826	1,150,439	356,551	589,676	1,385,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.852257	6.029713	0.543647	1.341707	46.822245	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,900	69,849	37,611	69,833	57,206	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.789159	0.366094	0.057347	0.158893	1.932831	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: 14-0077

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

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Cost Center Description			SOCIAL SERVICE	
			(TIME SPENT)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	173,581	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	59,267	30.00
43.00	04300	NURSERY	5,749	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	24,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,472	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,593	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	64,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,581	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	194.01
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)	327,232	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.885183	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,767	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.062029	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
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				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	16,160,842		16,160,842	5,776	16,166,618	30.00	
43.00	04300	NURSERY	570,369		570,369	0	570,369	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,621,637		3,621,637	0	3,621,637	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	784,399		784,399	0	784,399	52.00	
53.00	05300	ANESTHESIOLOGY	22,088		22,088	0	22,088	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,399,083		3,399,083	0	3,399,083	54.00	
60.00	06000	LABORATORY	4,133,782		4,133,782	0	4,133,782	60.00	
65.00	06500	RESPIRATORY THERAPY	1,610,722	0	1,610,722	0	1,610,722	65.00	
66.00	06600	PHYSICAL THERAPY	858,760	0	858,760	0	858,760	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	261,255		261,255	0	261,255	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,537		214,537	0	214,537	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,110,394		2,110,394	0	2,110,394	73.00	
74.00	07400	RENAL DIALYSIS	55,087		55,087	0	55,087	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,841,478		1,841,478	3,632	1,845,110	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	5,996,368		5,996,368	0	5,996,368	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,410,476		1,410,476		1,410,476	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	868,844		868,844		868,844	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	43,920,121	0	43,920,121	9,408	43,929,529	200.00	
201.00		Less Observation Beds	1,410,476		1,410,476		1,410,476	201.00	
202.00		Total (see instructions)	42,509,645	0	42,509,645	9,408	42,519,053	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
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			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,471,614		12,471,614			30.00
43.00	04300	NURSERY	62,140		62,140			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	188,024	1,308,365	1,496,389	2.420251	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,502	30,078	99,580	7.877074	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	60,841	494,177	555,018	0.039797	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,183	6,139,758	6,618,941	0.513539	0.000000	54.00
60.00	06000	LABORATORY	1,608,385	14,256,007	15,864,392	0.260570	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	352,023	981,358	1,333,381	1.207998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	16,420	1,415,597	1,432,017	0.599686	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,733	505,437	612,170	0.426769	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,184	218,938	250,122	0.857729	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	409,869	457,161	867,030	2.434050	0.000000	73.00
74.00	07400	RENAL DIALYSIS	22,248	15,450	37,698	1.461271	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	558	1,551,479	1,552,037	1.186491	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	911,484	7,713,046	8,624,530	0.695269	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,325	592,646	596,971	2.362721	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	183,652	183,652			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,794,533	35,863,149	52,657,682			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,794,533	35,863,149	52,657,682			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2.420251		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7.877074		52.00
53.00	05300	ANESTHESIOLOGY	0.039797		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.513539		54.00
60.00	06000	LABORATORY	0.260570		60.00
65.00	06500	RESPIRATORY THERAPY	1.207998		65.00
66.00	06600	PHYSICAL THERAPY	0.599686		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.426769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.857729		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.434050		73.00
74.00	07400	RENAL DIALYSIS	1.461271		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188831		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.695269		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.362721		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
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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		993,644	0	993,644	9,307	106.76	30.00
43.00	NURSERY		31,823		31,823	67	474.97	43.00
200.00	Total (lines 30 through 199)		1,025,467		1,025,467	9,374		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		1,579	168,574				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		1,579	168,574	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/28/2020 11:28 am			
				Title XVIII		Hospital		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	365,744	1,496,389	0.244418	17,577	4,296	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,886	99,580	0.229825	2,655	610	52.00	
53.00	05300	ANESTHESIOLOGY	727	555,018	0.001310	9,741	13	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,286	6,618,941	0.042346	102,563	4,343	54.00	
60.00	06000	LABORATORY	93,171	15,864,392	0.005873	304,964	1,791	60.00	
65.00	06500	RESPIRATORY THERAPY	87,766	1,333,381	0.065822	81,874	5,389	65.00	
66.00	06600	PHYSICAL THERAPY	61,119	1,432,017	0.042680	5,718	244	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,977	612,170	0.014664	22,556	331	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,372	250,122	0.029474	18,672	550	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	68,663	867,030	0.079193	90,451	7,163	73.00	
74.00	07400	RENAL DIALYSIS	344	37,698	0.009125	11,742	107	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	118,848	1,552,037	0.076575	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00	
91.00	09100	EMERGENCY	281,834	8,624,530	0.032678	209,658	6,851	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	86,692	596,971	0.145220	4,325	628	92.00	
200.00		Total (lines 50 through 199)	1,484,429	39,940,276		882,496	32,316	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0077		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/28/2020 11:28 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
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	9,307	0.00	1,579	30.00			
43.00	04300	NURSERY	0	0	67	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	9,374		1,579	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
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: 14-0077

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0077		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 11:28 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,496,389	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	99,580	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	555,018	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,618,941	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,864,392	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,333,381	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,432,017	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	612,170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	250,122	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	867,030	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	37,698	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,552,037	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	8,624,530	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	596,971	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,940,276		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0077

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

Worksheet D
Part IV
Date/Time Prepared:
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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	17,577	0	122,105	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,655	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	9,741	0	34,252	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	102,563	0	610,591	0
60.00	06000	LABORATORY	0.000000	304,964	0	346,786	0
65.00	06500	RESPIRATORY THERAPY	0.000000	81,874	0	101,896	0
66.00	06600	PHYSICAL THERAPY	0.000000	5,718	0	73	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,556	0	51,380	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	18,672	0	25,413	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	90,451	0	44,185	0
74.00	07400	RENAL DIALYSIS	0.000000	11,742	0	1,854	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	102,786	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	209,658	0	654,055	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,325	0	63,399	0
200.00		Total (lines 50 through 199)		882,496	0	2,158,775	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/28/2020 11:28 am

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2.420251	122,105	0	0	295,525	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	7.877074	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.039797	34,252	0	0	1,363	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.513539	610,591	0	0	313,562	54.00	
60.00	06000	LABORATORY	0.260570	346,786	0	0	90,362	60.00	
65.00	06500	RESPIRATORY THERAPY	1.207998	101,896	0	0	123,090	65.00	
66.00	06600	PHYSICAL THERAPY	0.599686	73	0	0	44	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.426769	51,380	0	0	21,927	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.857729	25,413	0	0	21,797	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2.434050	44,185	0	1,852	107,548	73.00	
74.00	07400	RENAL DIALYSIS	1.461271	1,854	0	0	2,709	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.186491	102,786	0	0	121,955	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.695269	654,055	0	0	454,744	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.362721	63,399	0	0	149,794	92.00	
200.00		Subtotal (see instructions)		2,158,775	0	1,852	1,704,420	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		2,158,775	0	1,852	1,704,420	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
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			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,508		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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	4,508		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,508		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 11:28 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,307	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,307	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			8,495	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)			1,579	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)			16,166,618	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)			16,166,618	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)			16,166,618	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)			1,737.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,742,786	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)			2,742,786	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0077

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

Worksheet D-1

Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					717,260 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,460,046 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)					168,574 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					32,316 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					200,890 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,259,156 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)					812 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,737.04 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,410,476 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0077

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

Worksheet D-1

Date/Time Prepared:
8/28/2020 11:28 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	993,644	16,166,618	0.061463	1,410,476	86,692	90.00
91.00 Nursing School cost	0	16,166,618	0.000000	1,410,476	0	91.00
92.00 Allied health cost	0	16,166,618	0.000000	1,410,476	0	92.00
93.00 All other Medical Education	0	16,166,618	0.000000	1,410,476	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/28/2020 11:28 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		2,301,410		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2.420251	17,577	42,541	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7.877074	2,655	20,914	52.00
53.00	05300 ANESTHESIOLOGY	0.039797	9,741	388	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.513539	102,563	52,670	54.00
60.00	06000 LABORATORY	0.260570	304,964	79,464	60.00
65.00	06500 RESPIRATORY THERAPY	1.207998	81,874	98,904	65.00
66.00	06600 PHYSICAL THERAPY	0.599686	5,718	3,429	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.426769	22,556	9,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.857729	18,672	16,016	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2.434050	90,451	220,162	73.00
74.00	07400 RENAL DIALYSIS	1.461271	11,742	17,158	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188831	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.695269	209,658	145,769	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.362721	4,325	10,219	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		882,496	717,260	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)		882,496		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
8/28/2020 11:28 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			2,338,159	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	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)			5,976	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	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)			120.78	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)			24.99	30.00
31.00	Percentage of Medicaid patient days (see instructions)			57.21	31.00
32.00	Sum of lines 30 and 31			82.20	32.00
33.00	Allowable disproportionate share percentage (see instructions)			57.03	33.00
34.00	Disproportionate share adjustment (see instructions)			333,363	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000131134	0.000105606
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,084,852	881,870
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		811,410	221,672
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,033,082	
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)		3,710,580	
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)		3,710,580	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		227,710	
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)		3,938,290	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,938,290	
62.00	Deductibles billed to program beneficiaries		302,517	
63.00	Coinurance billed to program beneficiaries		17,732	
64.00	Allowable bad debts (see instructions)		197,737	
65.00	Adjusted reimbursable bad debts (see instructions)		128,529	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		197,737	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,746,570	
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)		49,976	
70.94	HRR adjustment amount (see instructions)		-2,960	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,793,586	71.00
71.01	Sequestration adjustment (see instructions)		75,872	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		3,744,668	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)		-26,954	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,508	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,704,420	2.00
3.00	OPPS payments		748,787	3.00
4.00	Outlier payment (see instructions)		1,676	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)		4,508	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,852	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)		1,852	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)		1,852	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		2,656	20.00
21.00	Lesser of cost or charges (see instructions)		1,852	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)		750,463	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)		173,746	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)		578,569	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)		578,569	30.00
31.00	Primary payer payments		145	31.00
32.00	Subtotal (line 30 minus line 31)		578,424	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)		56,653	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		36,824	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,653	36.00
37.00	Subtotal (see instructions)		615,248	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		615,248	40.00
40.01	Sequestration adjustment (see instructions)		12,305	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		680,430	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)		-77,487	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: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/28/2020 11:28 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,702,061		654,987	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/07/2019	42,607	08/07/2019	25,443	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)		42,607		25,443	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,744,668		680,430	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		26,954		77,487	6.02
7.00	Total Medicare program liability (see instructions)		3,717,714		602,943	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0077

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

Worksheet G

Date/Time Prepared:
8/28/2020 11:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,488,471	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	3,461,920	0	0	0	4.00
5.00	Other receivable	237,119	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	318,365	0	0	0	7.00
8.00	Prepaid expenses	631,346	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)	7,137,221	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,222,647	0	0	0	12.00
13.00	Land improvements	307,583	0	0	0	13.00
14.00	Accumulated depreciation	-275,547	0	0	0	14.00
15.00	Buildings	30,677,647	0	0	0	15.00
16.00	Accumulated depreciation	-16,093,920	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	788,179	0	0	0	19.00
20.00	Accumulated depreciation	-262,062	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	13,779,111	0	0	0	23.00
24.00	Accumulated depreciation	-11,959,552	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	486,565	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,670,651	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,732,077	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,732,077	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,539,949	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,164,246	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,741,358	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,074,483	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	1,758,319	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,738,406	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,988,194	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,927,440	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,915,634	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,654,040	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	8,885,909				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	8,885,909	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,539,949	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0077

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

Worksheet G-1

Date/Time Prepared:
8/28/2020 11:28 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,728,561		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,996,528				2.00
3.00	Total (sum of line 1 and line 2)		8,732,033		0		3.00
4.00	TRANSFER FROM RELATED PARTY	9,383		0		0	4.00
5.00	ASSETS WITH DONOR RESTRICTIONS	144,493		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		153,876		0		10.00
11.00	Subtotal (line 3 plus line 10)		8,885,909		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,885,909		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	TRANSFER FROM RELATED PARTY		0				4.00
5.00	ASSETS WITH DONOR RESTRICTIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0077

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,533,754		12,533,754	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,533,754		12,533,754	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,533,754		12,533,754	17.00
18.00	Ancillary services	3,344,971	27,373,804	30,718,775	18.00
19.00	Outpatient services	915,809	8,305,692	9,221,501	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		183,652	183,652	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	PHYSICIAN PRIVATE OFFICES	1,239,719	8,471,524	9,711,243	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,034,253	44,334,672	62,368,925	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,934,853		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)		56,934,853		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0077

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

Worksheet G-3

Date/Time Prepared:
8/28/2020 11:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,368,925	1.00
2.00	Less contractual allowances and discounts on patients' accounts	10,038,993	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,329,932	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,934,853	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,604,921	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	293	6.00
7.00	Income from investments	9,623	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	466	10.00
11.00	Rebates and refunds of expenses	4,655	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	255,623	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	448	17.00
18.00	Revenue from sale of medical records and abstracts	37,439	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	17,172	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	1,046,126	24.00
24.01	MISCELLANEOUS INCOME	236,548	24.01
25.00	Total other income (sum of lines 6-24)	1,608,393	25.00
26.00	Total (line 5 plus line 25)	-2,996,528	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,996,528	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0077

Period:

Worksheet H

HHA CCN: 14-7315

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

Date/Time Prepared:
8/28/2020 11:28 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	197,408	14,427	6,017	0	39,073	256,925	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	162,026	11,841	4,938	0	0	178,805	6.00
7.00 Physical Therapy	41,759	3,052	1,273	0	0	46,084	7.00
8.00 Occupational Therapy	1,934	141	59	29,471	0	31,605	8.00
9.00 Speech Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	1,786	131	54	0	0	1,971	10.00
11.00 Home Health Aide	0	0	0	0	0	0	11.00
12.00 Supplies (see instructions)	0	0	0	0	75	75	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	404,913	29,592	12,341	29,471	39,148	515,465	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	0	256,925	0	256,925			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	178,805	0	178,805			6.00
7.00 Physical Therapy	0	46,084	0	46,084			7.00
8.00 Occupational Therapy	0	31,605	0	31,605			8.00
9.00 Speech Pathology	0	0	0	0			9.00
10.00 Medical Social Services	0	1,971	0	1,971			10.00
11.00 Home Health Aide	0	0	0	0			11.00
12.00 Supplies (see instructions)	0	75	0	75			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	0	515,465	0	515,465			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/28/2020 11:28 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
									0
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	256,925	0	0	0	0	256,925	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	178,805	0	0	0	0	178,805	6.00	
7.00	Physical Therapy	46,084	0	0	0	0	46,084	7.00	
8.00	Occupational Therapy	31,605	0	0	0	0	31,605	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	1,971	0	0	0	0	1,971	10.00	
11.00	Home Health Aide	0	0	0	0	0	0	11.00	
12.00	Supplies (see instructions)	75	0	0	0	0	75	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	515,465	0	0	0	0	515,465	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	256,925						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	177,687	356,492					6.00	
7.00	Physical Therapy	45,796	91,880					7.00	
8.00	Occupational Therapy	31,408	63,013					8.00	
9.00	Speech Pathology	0	0					9.00	
10.00	Medical Social Services	1,959	3,930					10.00	
11.00	Home Health Aide	0	0					11.00	
12.00	Supplies (see instructions)	75	150					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		515,465					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/28/2020 11:28 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-256,925	258,540
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	178,805	6.00
7.00	Physical Therapy	0	0	0	0	46,084	7.00
8.00	Occupational Therapy	0	0	0	0	31,605	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	1,971	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	75	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-256,925	258,540
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		256,925
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.993753

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/28/2020 11:28 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	43,888	43,888	13,696	1.00
2.00	Skilled Nursing Care	356,492	0	0	36,022	392,514	122,495	2.00
3.00	Physical Therapy	91,880	0	0	9,284	101,164	31,571	3.00
4.00	Occupational Therapy	63,013	0	0	430	63,443	19,799	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	3,930	0	0	397	4,327	1,350	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	150	0	0	0	150	47	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	515,465	0	0	90,021	605,486	188,958	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	5,539	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	5,539	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/28/2020 11:28 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Home Health Agency I SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	37,366	1,149	0	0	0	101,638	1.00
2.00	Skilled Nursing Care	22,979	0	0	0	0	537,988	2.00
3.00	Physical Therapy	6,952	0	0	0	0	139,687	3.00
4.00	Occupational Therapy	205	0	0	0	0	83,447	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	109	0	0	0	0	5,786	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	197	8.00
9.00	Drugs	0	0	101	0	0	101	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	67,611	1,149	101	0	0	868,844	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	101,638					1.00
2.00	Skilled Nursing Care	0	537,988	71,272	609,260			2.00
3.00	Physical Therapy	0	139,687	18,505	158,192			3.00
4.00	Occupational Therapy	0	83,447	11,055	94,502			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	5,786	767	6,553			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	197	26	223			8.00
9.00	Drugs	0	101	13	114			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	868,844	101,638	868,844			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.132478				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/28/2020 11:28 amHome Health
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	0	197,408	0	43,888	0	1.00
2.00	Skilled Nursing Care	0	0	162,026	0	392,514	0	2.00
3.00	Physical Therapy	0	0	41,759	0	101,164	0	3.00
4.00	Occupational Therapy	0	0	1,934	0	63,443	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	1,786	0	4,327	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	150	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	404,913		605,486	0	20.00
21.00	Total cost to be allocated	0	0	90,021		188,958	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.222322		0.312077	0.000000	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	130	0	0	6,197	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	3,811	2.00
3.00	Physical Therapy	0	0	0	0	0	1,153	3.00
4.00	Occupational Therapy	0	0	0	0	0	34	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	18	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	130	0	0	11,213	20.00
21.00	Total cost to be allocated	0	0	5,539	0	0	67,611	21.00
22.00	Unit cost multiplier	0.000000	0.000000	42.607692	0.000000	0.000000	6.029698	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/28/2020 11:28 amHome Health
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	2,113	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	75	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	2,113	75	0	0			20.00
21.00	Total cost to be allocated	1,149	101	0	0			21.00
22.00	Unit cost multiplier	0.543777	1.346667	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/28/2020 11:28 am

				Title XVIII		Home Health Agency I	PPS
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	609,260		609,260	503	1,211.25
2.00	Physical Therapy	3.00	158,192	0	158,192	664	238.24
3.00	Occupational Therapy	4.00	94,502	0	94,502	27	3,500.07
4.00	Speech Pathology	5.00	0	0	0	0	0.00
5.00	Medical Social Services	6.00	6,553		6,553	16	409.56
6.00	Home Health Aide	7.00	0		0	0	0.00
7.00	Total (sum of lines 1-6)		868,507	0	868,507	1,210	
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	0		8.00
9.00	Physical Therapy		41180	0	0		9.00
10.00	Occupational Therapy		41180	0	0		10.00
11.00	Speech Pathology		41180	0	0		11.00
12.00	Medical Social Services		41180	0	0		12.00
13.00	Home Health Aide		41180	0	0		13.00
14.00	Total (sum of lines 8-13)			0	0		14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	223	0	223	0	0.000000
16.00	Cost of Drugs	9.00	114	0	114	0	0.000000
				Program Visits		Cost of Services	
				Part B		Part B	
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	0		0	0	1.00
2.00	Physical Therapy	0	0		0	0	2.00
3.00	Occupational Therapy	0	0		0	0	3.00
4.00	Speech Pathology	0	0		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	0		0	0	6.00
7.00	Total (sum of lines 1-6)	0	0		0	0	7.00
		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
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Title XVIII

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Cost Center Description		Program Covered Charges			Cost of Services	Agency 1			
		Part A	Part B			Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00		9.00	10.00	11.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0						1.00	
2.00	Physical Therapy	0						2.00	
3.00	Occupational Therapy	0						3.00	
4.00	Speech Pathology	0						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	0						6.00	
7.00	Total (sum of lines 1-6)	0						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/28/2020 11:28 am

Title XVIII

Home Health
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.599686	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.426769	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	2.434050	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 HHA CCN: 14-7315	Period: From 01/01/2019 To 12/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	0
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0
13.00	Total PPS Reimbursement - LUPA Episodes		0	0
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	0
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	0
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	0
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	0
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	0
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	0
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0077

Period:

Worksheet H-5

HHA CCN: 14-7315

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

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Home Health
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		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		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		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0077	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/28/2020 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		192,248	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		627	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)		23.29	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)		24.99	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		57.21	8.00
9.00	Sum of lines 7 and 8		82.20	9.00
10.00	Allowable disproportionate share percentage (see instructions)		18.12	10.00
11.00	Disproportionate share adjustment (see instructions)		34,835	11.00
12.00	Total prospective capital payments (see instructions)		227,710	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